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The manual is designed to be used in training socially disadvantaged persons who have had no previous job experience in the health fields and who may have only a fifth grade reading ability to function as (1) community health aides who present information received from a qualified source in laymen's language and in general assume the "expediter" role as a link between the client and the community's professional health resources, and (2) home health aides who function mainly to provide personal care in the home. The first three chapters introduce the trainer to the program and provide suggestions for presenting and implementing the training program. The fourth chapter outlines a basic curriculum for all health service trainees. The fifth and sixth outline the specialty skill curriculums for home health aides and community health aides respectively. It is expected that the contents will be refined and expanded to meet local needs. (JK)

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NEW CAREERS

THE COMMUNITY/HOME HEALTH AIDE

Trainer's Manual

U.S. Department of Labor
Manpower Administration
Bureau of Work-Training Programs

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Prepared and published by:
New Careers Institute
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NEW CAREERS: THE COMMUNITY/HOME HEALTH AIDE TRAINER'S MANUAL

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TABLE OF CONTENTS

Preface v

New Careers Glossary vii

I. TRAINING COMMUNITY/HOME HEALTH AIDES 1

II. TYPICAL PROBLEMS AND RECOMMENDED SOLUTIONS 9

III. ORGANIZATION AND STRUCTURE OF THE PROGRAM 11

IV. BASIC HEALTH CURRICULUM 23
  The Health Service Aide 25
  Biological Potential and Equilibrium 31
  Professionals in the Health Fields 33
  Public Health Administration 37
  The Human Body 45
  Conception 65
  Growth and Development 73
  Nutrition 87
  Accidents 101
  Epidemiology 105
  Selected Chronic Diseases 109
  Infectious Diseases 123
  First Aid 127
  Interviewing Skills 129
  Recording Skills 135
  Evaluation 139

V. THE HOME HEALTH AIDE SPECIALTY CURRICULUM 141
  The Patient 143
  Total Care Plan and Home Health Aide Care Plan 145
  Bedside Care 149
  Range of Motion Exercises 151
  Housekeeping Practices 153
  Care of the Infant 155

VI. THE COMMUNITY HEALTH AIDE SPECIALTY CURRICULUM 157
  The Family 159
  Family Health Needs 161
  Selected Community Health Problems and Needs 165
  Community Resources 173
  Environmental Health and Home Sanitation 175
  Referrals 181
  Eligibility Requirements for Community Health Programs 185
  Assisting Patients to Community Health Services 187
  Care of Other Family Members 191
  Interdisciplinary Conferences 195
  Community Organization 199
  Group Teaching 203
  Working with Other Persons in the Helping Role 207

Selected Concepts and Substantive Elements
  Related to the New Careers Training Model 211

PREFACE

The Community/Home Health Aide Trainer's Manual is one of a series of manuals produced by the New Careers Institute of the University Research Corporation. Under contract to the U.S. Department of Labor, Manpower Administration, Bureau of Work-Training Programs, the University Research Corporation is publishing and distributing these materials through its Information Clearinghouse on New Careers as part of a broad spectrum of technical assistance in program development, job and career design, curriculum writing, and training to New Careers programs across the country.

This manual is designed to be used in training Community/Home Health workers who will assume subprofessional positions at the entry level. This training program represents one in a number of first steps in a New Careers lattice in the field of health services. The material is structured for use with socially disadvantaged persons who have a fifth grade reading ability and who have not had any real previous job experience in the health fields.

The New Careers rationale for training health aides and workers is based on several elementary assumptions:

1. The growing need for expanded health services throughout the country requires a corresponding increase in the number of people who have been trained and who are qualified to meet this service need.
2. Given the necessary job and career opportunity, support, and training, the unemployed, underemployed, and disadvantaged of our nation can effectively fill these positions and participate in programs that are designed to raise the delivery capability of health services to optimum level.
3. People who are recruited from the area being served provide an effective and unique link between the community and the health agency, thereby enhancing the effectiveness of the agency in which the workers are employed.
4. Using New Careers subprofessionals in an integrated program of health services frees the professional to work more effectively.
5. Real job opportunities and training provide an important answer to the need of the disadvantaged for motivation, involvement, training, and careers with growth potential.

It is particularly important, as is noted in the manual, that:

(a) Careful attention be given to developing realistic and concrete positions, with task expectations and responsibilities defined as clearly as possible.
(b) Supervisors, trainers, and professional workers be familiarized with the program design expectations and oriented to effectively using these workers.
(c) An exploratory and flexible posture be maintained in both development and training to ensure that a maximally effective model for local needs is realized.

The manual is based on actual experience in training aides for these positions in demonstration programs in Washington, D. C., New York, California and other areas. At the same time, it is not to be regarded as a rigid format, but rather as a program that is to be refined and expanded to meet local needs. Additional references and audiovisual materials are recommended in the body of the manual and should be used to expand the scope of the course material. We encourage the trainer to approach the material creatively and to involve the trainees in the learning experience as completely as possible.

Chapters I, II, and III introduce the trainer to the program, and provide suggestions for presenting and implementing a New Careers training program. Chapter IV outlines a basic (core) curriculum for all health service trainees; Chapter V, the specialty skill curriculum for Home Health Aides; and Chapter VI, the specialty skill curriculum for Community Health Aides. These three chapters are keyed to parallel the three parts of the companion manual, *The Community/Home Health Aide Trainee's Manual.*

Supplemental material that covers other aspects of entry-level New Careers training can be found in:

1. *Entry Training for New Careers**
2. *Position Descriptions for New Careers**
3. *Generic Training in the Human Services, (trainer and trainee manuals)**

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A NEW CAREERS GLOSSARY

Some brief definitions to help readers understand the fundamental concepts of New Careers and the New Careers Training Model. . .

Human Services – Broadly defined as the fields of public service in which a person-to-person relationship, crucial to the provision of services, exists between the receivers and the providers of the services. Includes the fields of health, education, mental health, social services, recreation, law enforcement, corrections, rehabilitation, housing and employment.

Human Service Aides – Persons trained in New Careers programs to assume aide responsibilities and assist professionals in the delivery of human services.

Entry Training – The initial phases of the training program; required to prepare trainees to assume entry-level or first-level jobs.

Career Ladders – The vertical hierarchy of jobs in human services from the level of human service aide through the entire progression of career potentials.

Entry-Level Jobs – The first step in the career ladder, requiring minimal skill and education and open to previously uncredentialed persons. Sometimes called first-level positions.

Task Cluster – The conglomerate of tasks required in a particular job.

Generic Issues in Human Services – Those broad issues common to all human services, including 1) The Individual's Relationship to the World of Work; 2) His Relationship to People; 3) His Relationship to the Community, and 4) Individual Growth and Development.

Training in Generic Issues – Training and curriculum content related to the generic issues of human services.

Basic Training in a Particular Human Service Field – Training in the basic concepts and skills common to a particular human service field.

Job Skill Training – Training in the particular skills and knowledge required to do a specific job.

On-the-Job Training – Structured, planned and supervised training in the actual work situation during which the trainee performs the work and role required of him, i.e., learning through doing.

Remediation (or Remedial Training) – Training in the basic educational skills required to most efficiently learn and carry out job duties, including preparation for educational and Civil Service qualifications.

Core-Group Technique – A technique used by the New Careers trainers as they work with trainees in small groups, providing training, counseling, discussion and feedback related to job experiences as well as group identity and support.

Certification and Accreditation – Official, documented recognition by human service agencies or academic institutions (such as junior colleges) certifying New Careerists for the jobs they assume and/or leading to further academic or educational degrees.

Training for Supervisors and Trainers – A structured training program that includes consideration of:

New Careers concepts,
Restructuring the job hierarchy,
Understanding the life styles of trainees,
Supervisory models and skills and
Roles and relationships between trainers, supervisors and trainees.

I. TRAINING COMMUNITY/HOME HEALTH AIDES

Purpose of This Manual

This manual is intended to provide the guidelines needed to prepare lay persons to be community and/or home health aides. These aides will be able to provide assistance to professional health workers in community or home health services.

The *community health aide* is concerned with family health needs, with environmental health, and with those community organizations that function to protect and improve the health of the public. The *home health aide's* primary concern is meeting individual health needs in the home setting – giving bedside care and establishing and maintaining a milieu of therapeutic and preventive care for a physically and/or mentally ill patient in his home.

This manual has three major sections:

1. Introduction and basic health curriculum,
2. Community health aide curriculum, and
3. Home health aide curriculum.

This division of subject matter corresponds to the New Careers philosophy that there is a nucleus or "core" of information that can serve as the basic curriculum content for training both kinds of aides. The training provided in the basic health curriculum establishes the necessary foundation on which specialty area training can be built.

Figure 1. *Diagram of Training Model*

Basic Curriculum in the Health Services	**Community Health Aide Specialty Area**
	Home Health Aide Specialty Area

Who Conducts the Training Program?

The 1966 amendments to the Economic Opportunity Act gave impetus to the establishment of training programs for human service aides generally and health aides in particular. Training programs for health aides are being conducted by universities, junior colleges, home health agencies, neighborhood health clinics, hospitals and public health departments. The needs and resources of individual communities have determined in part what kinds of institutions have done the training.

If a university or junior college is the training agency, it must have the technical staff (nurses, physicians, nutritionists, etc.) to teach the specialty area curriculum. If faculty members at the school cannot be spared to do the teaching, a contract with the local health department can be effective in providing needed teachers. Student health service staff can also serve as teachers.

In the home health agency, which is primarily a service agency, it is unlikely to have available training personnel; if it conducts a training program, it may also have to hire additional staff. Personnel might be hired on a part-time basis to assist staff members who handle the teaching duties. Members of the medical advisory board might also be able to participate as trainers.

It is most desirable for a health aide training program to be operated as a part of a comprehensive health agency such as a neighborhood health clinic or public health department rather than as part of an independent agency.

This does not mean that the health aide program should not maintain intrinsic autonomy. To the contrary, the program should operate within a framework that allows for new approaches and growth. Reiff and Riessman[1] have stated that the indigenous nonprofessional must be able to depend on an independent or somewhat independent source of power and authority; otherwise his function may be subverted by the other needs of the agency.

A sound community/home health aide training program must have a skilled person in authority to whom all the trainees are responsible. To ensure the most effective transition from knowledge to practice, a single staff member should function as supervisor and trainer. This negates the possibility of differences in opinion between a supervisor and a trainer that could undermine the entire program, and cause anxiety and frustration among the aides and confusion among professional staff on optimum utilization of aides.

Following accepted administrative principles, the health aide should be responsible to one, and only one, supervisor. Equally sound and essential, the supervisor/trainer should have both the authority commensurate with this responsibility and a realistic supervisory load. To enable the health aide supervisor/trainer to carry out his responsibility most effectively, he should be on the same level as other supervisors in the training agency and should be responsible to the administrator who coordinates all departmental activities. The supervisor/trainer and other department supervisors in the agency should meet periodically to discuss matters of mutual concern.

Regardless of the type of training institution, new intra-agency relationships and referral procedures should be worked out as soon as possible. The teaching staff and trainees should become acquainted with personnel of other departments and/or agencies with whom they will interact. This can be accomplished very easily by visits to other agencies. During these visits, staff members at various levels can meet each other and discuss how the role of the health aide can best be interpreted to other agencies. They can also discuss types of cases to be handled by the health aides. Interagency conferences can be planned.

Early establishment of interagency relationships is particularly vital for a university training program. Since many universities will probably have to rely on a health agency to provide the experience component of the training course, early arrangements will greatly facilitate sound planning and effective implementation of the program.

Qualifications of the Community/Home Health Aide Training Supervisor

There are two kinds of professional health workers who have the educational background that prepares them to train health aides: the health educator and the public health nurse. Both have the background for training the community health aide who is primarily concerned with preventive health services or motivating persons to utilize existing health facilities. But the home health aide who gives personal care should be trained by the public health nurse. Either trainer must meet these specific qualifications:

1. This person must appreciate the unique contribution that a nonprofessional can make in the improvement and delivery of health services.
2. The person must accept and be willing to be innovative and try out new ideas.
3. The public health nurse must have the qualifications as outlined by the official health department: a minimum of a baccalaureate degree from an accredited school of nursing that is also accredited in public health; at least one year's experience in a public health nursing agency under the supervision of a qualified public health nursing supervisor, and education courses on the bachelor or master's level.
4. The health educator must have the minimum of a master's degree in health education from an accredited school of public health or university with a graduate program in community health education.

Qualifications of the Community/Home Health Aide Trainee

1. The trainee must have an appreciation of the hardships that beset his fellow neighbor – this appreciation can be derived either from experience or close association with his neighbors. He must also be of the same economic, educational, and social level as the average person to be reached by health services.
2. The trainee needs to feel that he is part of the local community, and neighborhood residents must recognize him as part of it. He must be respected and liked by others in the neighborhood.
3. He must have demonstrated a sincere interest in others in the local community, have been a neighbor who has helped others in times of need, and must have demonstrated an interest in community problems that affect his peers.
4. No specific educational achievement is required, but the trainee must demonstrate ability to read and write well enough to comprehend instructions and accurately complete records.
5. He must have an outgoing personality, be friendly and enjoy working with individuals and groups.
6. The trainee must be articulate enough to give adequate instructions to others.

Methods for Recruiting Community/Home Health Aide Trainees

1. Contact local community action agency and state and federal employment agencies. Contact area ministers, priests and rabbis for names of persons who may meet the qualifications of trainees.
2. Invite applications from formal groups (P.T.A., civic associations, block clubs, church groups) as well as informal groups (bridge clubs, mothers' clubs, and back-fence groups).
3. Advertise on local radio stations listened to by residents that are to be served.
4. Contact settlement house personnel for names of potential health aides.
5. Newspaper advertisements may be quite helpful in some localities.
6. Invite area public health nurses, social workers, public housing project directors, school principals, and other persons who work closely with area residents to suggest potential trainees.

Suggested Functions and Selected Case Histories of Community/Home Health Aides

Two basic types of health aides have emerged as a result of needs within local communities.

Community Health Aide Functions:

Cornely and Bigman[2] state that a person at the "practical" level is needed to reach low-income families. Such a person would come from the same environment as the families served, talk their language, be well acquainted with the "gatekeepers," and able to develop meaningful contacts through nonverbal communications. This community health aide would receive professional direction from well-qualified health workers who provide him with accurate information that he can present in laymen's patterns of language and in terms of their health knowledge and attitudes. Reiff and Riessman[1] described this "expediter" role as a link between the client and the community's professional health resources.

Here are the functions of the *community health aide:*

1. Motivates patients and families to seek health care – providing support, showing interest, conveying understanding, maintaining a friendly relationship, and using other neighborly techniques.
2. Interprets the importance of seeking preventive care and early treatment of disease.
3. Instructs individuals in the home and in groups regarding primary prevention (all those measures that promote health such as proper nutrition, good personal hygiene, good housekeeping practices, proper rest, adequate ventilation, adequate exercise, etc.).
4. Assists in evaluating the health needs of each family member under close supervision of his supervisor, for example, by referral to appropriate agencies of a mother who needs prenatal care; a school-age child who needs eye or dental care; a father who needs a physical examina-

tion; a grandmother who needs follow-up care for her known diabetic condition; a preschool child who never had child health supervision, or a child who appears mentally retarded and should be examined.

5. Assists in determining priorities of health needs and in developing a plan of care, under the close supervision of the health aide trainer/supervisor.
6. Informs the family of available community health facilities where their specific needs can be met.
7. Assists in interpreting the eligibility requirements of various health facilities to families.
8. Assists in making referrals to the appropriate health agency regarding care plans; ascertains whether the patient has actually obtained the service to which he was referred.
9. Accompanies a patient to the health facility when necessary.
10. Attends patients' children or elderly relatives in their home while the patient obtains care at a health facility.
11. Reports to the public health nurse, social workers, physician and other professionals significant findings in relation to health and social matters that come to his attention during the performance of his duties.
12. When appropriate, reinforces the instructions given by the professional and encourages the patient to follow orders.
13. Seeks persons in the neighborhood who have unattended health problems and initiates appropriate action.
14. Maintains an accurate record of contacts with families and of the services that have been provided.
15. Initiates, organizes and assists in implementing a program of health education classes under the supervision of the health aide trainer/supervisor.
16. Aids in initiating, organizing and implementing activities to motivate large numbers of persons to avail themselves of health services and health innovations, (e.g., mass immunization programs, x-ray screening programs, etc.).
17. Teaches the family sound housekeeping practices, accident prevention, good nutritional habits, and personal hygiene in order to bring about a more healthful life.
18. May perform some housekeeping duties while attending children or elderly relatives while other members of the family obtain care at a health facility. This most often involves preparing food and dressing infants and preschoolers.
19. Performs first aid measures when appropriate.
20. Helps specialist develop health literature directed to the educational level of the target population.
21. Participates in team conferences with professional staff regarding individual families.

These two case histories illustrate the combination of many of the functions of the community health aide:

1. *Case History:* *Admitted:* 1-20-64
Closed: 6-17-64

Neighborhood Health Aide Program

Background Information – Family of 7 children and 2 adults originally referred from a case-worker. The presenting problem was the need for an 11-year-old diabetic child to learn to administer her own insulin. Since this was a nursing problem, the case was immediately referred to the public health nurse, who visited the home and later called on the Neighborhood Health Aide Program (NHAP) requesting money for food since the family had nothing to eat at the time.

Social and Health Problems Found in the Home – On the initial visit, the community health aide gave the family $3.00 to buy food to alleviate the emergency situation. While she was there, the health aide spent approximately two hours getting to know the mother and listening to the problems the family was experiencing. The mother admitted that her preoccupation with inadequate heat, insufficient food, inadequate income, and marital conflicts often prevented her from attending to the health needs of the family. One specific example was that the diabetic child was unable to follow the prescribed diet "because there was not enough money to buy proper food with the $5.00 a week she received from her husband; and her frequently unemployed husband took the butter, cheese, and lard from the surplus food allotment and apparently sold them to partially support his alcoholic habit."

The numerous unattended health problems uncovered on the first visit included: (1) the mother was hard of hearing and did not wear her hearing aid because it was in need of repair; (2) the mother had discontinued her lipreading classes at the Washington Hearing Society; (3) two school-age children needed dental care; (4) the father was a chronic alcoholic; (5) the diabetic daughter was not following her diet; (6) the same diabetic daughter had glasses that were not worn because "they were unattractive", and (7) one child had been discontinued in the free school lunch program.

In spite of these tremendous problems, this mother was interested in the health and welfare of her family as evidenced by the regular attendance of the children in the Child Health Clinic and schools.

Summary of Sequence of Events – During a discussion with the project nurse, it was agreed that the hearing problem was most urgent and should be dealt with as early as possible to enable the mother to work more effectively with the family problems. The health aide quickly moved on this, and within three weeks, the hearing aid was repaired by the Office of Vocational Rehabilitation and the mother was once more attending lipreading classes. During this three-week period, the health aide established a fairly good relationship with the father and he requested reading materials relative to his "drinking problem." This material was obtained from the Health Education and Information Division, Department of Public Health, and given to the father with explanation of the contents.

The mother was quite concerned about the health of her diabetic daughter, so this problem received the next highest priority. The public health nurse was aware of the problem with the diabetic diet and worked to help the family understand the need for it. The health aide also worked on the problem of the "unattractive glasses." After a conversation with the eye clinic staff, the mother was reassured that the diabetic child had a future appointment date at which time the problem of the glasses could be discussed. The mother was told to encourage the child to wear the present pair until other arrangements could be made.

Following through on advice and plans initiated by the health aide, the two children with dental cavities went to the City Hospital Dental Clinic and subsequently to the School Dental Clinic for dental care. The mother, children, and school personnel were actively involved in planning to get the teeth repaired.

Unfortunately, NHAP was unable to persuade the school principal to reinstate the child in the free school lunch program at that time, but now the rules are less strict and practically any child who desires can participate in the program. During the entire time NHAP was active with the family, there was frequent communication between the health aide, public health nurse, and other appropriate health and welfare workers.

The social problems worsened – the father deserted the family; the family was evicted; the children were sent to Junior Village Home for unsheltered children; and the mother moved in with relatives who lived out of our service area. We reluctantly closed the case.

What is to be the future of this family? While accompanying a blind patient to the General Hospital Medical Clinic during the month of October 1964, the health aide met the mother on her way to the Eye Clinic with one of her children. She talked briefly with her and found out that the mother was following through on all of the health problems that the health aide encouraged her to work on, and, in addition, had made plans to take another child to the ringworm clinic the next day. Moreover, it was learned that the family (excluding the father) was reunited in adequate housing and was receiving a PAD grant. The mother is now able to give her family a more adequate diet and is attending to the health needs of her family as a result of self-motivation and determination.

We, in NHAP, feel that with this family the health aide has accomplished the ultimate goal – to motivate the family to take care of its own health needs by using family resources and by seeking out and utilizing the existing health facilities for health care.

2. *Case History* *Admitted:* 12-04-63
Closed: 12-31-65

Neighborhood Health Aide Program

Background Information – Family of 8 children and 1 adult was brought to the attention of NHAP by the health aide who lived in their public housing apartment building and knew the family. The community health aide discovered that the infant had sores on his body and that the mother had not sought medical care. In communicating with the deaf-mute mother it was learned that the mother had not obtained medical care for the infant because "she had no car fare and no one to care for the other children while she took the infant to the clinic."

Social and Health Problems Found in the Home–Because the mother was a deaf-mute, she had made very few friends but fortunately the health aide was a very close friend who had, in the past, helped her with her problems. The father had deserted the family several months earlier and the family was receiving a welfare grant. It was believed that the father sometimes visited the family, thereby threatening their only income source since the grant would probably be discontinued if a man were found in the home.

During the month of December 1963, several unattended health problems plagued this family. These problems included: (1) the infant had sores on his body; (2) a school-age child had sores in his mouth; (3) a school-age child had high fever, sore throat, and stiff neck; (4) a preschooler had a cut on the buttocks; (5) the mother developed severe pains in her abdomen; (6) later on, it was discovered that the mother was pregnant; and (7) three school-age children needed dental care. This mother seemed overwhelmed with the tremendous responsibilities she had to bear without the help of the father.

Summary of Sequence of Events – Since the infant's condition was the only health problem known initially, it was dealt with first. By the time the health aide had made all the arrangements for car fare and baby-sitting service, a school-age child had developed a different type of sore in his mouth. Therefore, the health aide encouraged the mother to take both children to the Pediatric Clinic the same day. The health aide noticed that in her haste the mother had forgotten to take the written referral slip to the clinic. The health aide was aware that this deaf-mute mother had in the past gone to clinics and not been seen by the doctor because she could not hear her name when called and she was too insecure to let the personnel know her problem. In fact, this insecurity had kept her from seeking medical care. The health aide called the clinic personnel to let them know that the mother was in the clinic and could not hear her name called. After the health aide explained the situation, the doctor did treat the children.

A week later, a son fell and cut his buttocks. The mother immediately summoned the health aide to determine the seriousness of the cut. The health aide saw that the cut was fairly deep and the child was bleeding so she advised the mother to take the child to the emergency room at once. This time the mother took the written referral slip with her when she went to the emergency room and the child was seen without delay.

One evening about 6:30 P.M. the mother sent for the health aide because her daughter felt very hot, had a stiff neck, and a sore throat. The health aide took the temperature because she knew that the mother could not read a thermometer. The temperature was 104.2°F. The health aide immediately called the home of the project nurse and was told that the condition could be very serious and the child should be taken to the hospital at once. The health aide called a taxi for the mother and helped her prepare the child for the trip. It was 10:30 P.M. before the child arrived at the emergency room, but she was seen right away because the health aide alerted the hospital staff. The child was not admitted, but return visits were made for additional treatment.

The health aide began to suspect that the mother might be pregnant again but it was not mentioned because the health aide was aware that the welfare check might be stopped if this mother became pregnant while receiving the grant. The health aide very skillfully worked with the mother and encouraged her to have a complete physical examination for "pains in the stomach." After the doctor told the mother that she was expecting, she verbally denied it. By the time the mother was four months pregnant, the health aide was successful in getting her to obtain prenatal care from the Health Department Prenatal Clinic. This was quite a feat since this mother had had no prenatal care during her previous pregnancies. The health aide baby-sat for the mother for subsequent visits. (Incidentally, the welfare grant was not discontinued when the social worker discovered that the mother was pregnant.)

During the time the mother was pregnant, the health aide made plans for three of the school-age children to be taken to a dental clinic. They went with a group of children that was periodically taken by NHAP to the Southwest Clinic for dental care. The mother seemed very grateful for the service, since she had not known dental care was available.

This particular health aide was responsible for initiating a thermometer reading class, and as would be expected, this mother was among the first class participants. She learned to read a thermometer as a result of attending the class.

When it was time for the mother to deliver, she looked to the health aide to assist her in preparing the children to stay with relatives. With the assistance of the health aide, the children were adequately dressed and had a sufficient supply of clothing for the short visit. The children were sent in a taxi to the home of their aunt, and the oldest child called the health aide to report their safe arrival.

This case is indicative of how the neighborly relationship was used in working with this family toward the betterment of their health. What has happened to this family? Following delivery, the mother kept her appointment for her postpartum examination without the encouragement of baby-sitting service or the health aide. The mother registered the newborn infant in the Child Health Clinic early enough so that it was seen when it was one month old. She takes the child to the clinic regularly.

The mother decided that she wanted information that would help her with family planning, so she registered in the Health Department Birth Control Clinic and has kept regular return appointments. Again, this was accomplished without the encouragement or services of the health aide. This mother apparently learned the value of medical care for illnesses and preventive health measures. Although the mother may not have overcome the insecure feeling stemming from her deaf-mute condition, at least she now has enough confidence to seek out health care for herself and her family. The health aide has achieved the ultimate goal of helping the family to become self-reliant in meeting its own health needs.

Home Health Aide Functions:

The second general type of health aide that has emerged functions mainly to provide "personal care." Most often, this health aide works in a program that is part of a nursing service agency or an organized home-care program in a public agency. The major objectives are to cure disease, rehabilitate patients and eliminate disease symptoms. The approach is patient-centered. The home health aide visits the patients in the home and performs those duties outlined by the staff public health nurse in conjunction with the health supervisor. The staff public health nurse visits the patient periodically to re-evaluate the nursing care plan and determine the progress or deterioration of the patient.

In this type of health aide program, the health aide is responsible to the health aide supervisor for training and supervision. The staff public health nurse and the health aide supervisor determine whether the patient can benefit from the services of a home health aide. The specific functions of the home health aide vary with the assignment, but some of the more common ones are:

1. Takes and records temperature, pulse, and respiration
2. Takes blood pressures
3. Makes beds (occupied and unoccupied)
4. Changes uncomplicated dressings
5. Provides patients with bedpans and urinals, cleaning utensils following use
6. Assists ambulatory patients or patients able to do partial bathing with baths
7. Gives complete bed baths
8. Combs hair, dresses patient, or assists with other personal care when necessary
9. Reminds the patient to take prescribed medications
10. Prepares meals for patient and feeds him when necessary
11. Performs simple treatments (enemas, range of motion exercises, assistance with cane and crutch walking, massages, special skin care)
12. Assists with or provides mouth care
13. Relays diet instructions to the patient and family
14. Informs the supervisor of progress or deterioration of the patient and of patient's response to the care given
15. Keeps accurate reports of the care given and significant findings during the course of caring for the patient
16. Participates in team conferences with professional staff

17. Recommends ways of improving care given to the patient in the home
18. Accompanies patient to a health service facility when necessary
19. Provides light housekeeping duties that are consistent with providing a therapeutic environment for the patient, as may be required.

The following case histories illustrate the combination of many of the above functions of the home health aide.

1. *Case History* *Admitted:* 5-10-65
Status: Active

Background Information – Miss A is a sixty-four-year-old female who was accepted in the Home Care Program on May 10, 1965. Her diagnoses at that time were cardiovascular attack (CVA) with right hemiplegia; diabetes mellitus, maturity onset type; diabetic neuropathy, neurogenic bladder secondary to diabetes, and hypertensive cardiovascular disease.

Social and Health Problems – Prior to patient's stroke, she was employed at the U.S. Treasury Department as a GS-2 clerk. She had worked at this agency for the past twenty-three years. As late as May 1965, five months after the onset of her illness, she had not applied for retirement, because she was hopeful she would recover from her stroke and return to work. Patient finally decided to fill out her retirement papers with the assistance of the social worker. At the time, she had no income, having used up all her annual leave, and her creditors were putting a great deal of pressure on her for their money. In July 1965, patient received her first retirement check of $154.00 a month, and a lump sum payment to cover the months of February through June in the amount of $690.00. Living in the home is patient's brother, age 45, disabled, receiving a Veterans Administration pension, and patient's mother, age 87, who receives a small pension of $45.00. Though aged, the mother is very alert and agile in her movements. The family home is paid for.

The patient is bedfast with a foley catheter. Total care is rendered by the aged mother, who also does household chores, meal preparation and washing.

It was the decision of the team members that the services of a health aide would be of great assistance to this patient in areas of personal care, physical therapy and occupational therapy.

Summary of Sequence of Events – Patient was seen initially by the physical therapist approximately five months after the CVA. At this time, she was a bed patient, totally dependent, even requiring feeding. Even in her uninvolved side, there were signs of weakness secondary to disuse. The involved extremities were spastic and without voluntary muscle action.

A health aide was assigned daily to render personal care and direct the patient in prescribed exercises: active, passive, and strengthening range of motion to all extremities. In addition, the patient was started on sitting exercises progressing to standing and balancing exercises in preparation for ambulation. This was incorporated with a constant reminder to the family to demand self-help from the patient.

The patient progressed rapidly. Within a month she was able to ambulate laboriously with the use of a posterior shell (to keep the knee extended), and a walker.

She was later able to dress slowly, transfer from wheelchair independently and partially bathe herself.

Occupational therapy was instituted and the patient was more motivated to get out of bed.

A permanent long leg and orthopedic brace was ordered because the patient showed a potential for independence even though she had not regained use of important active muscles on the involved side.

The patient mastered independent stair climbing, and progressed to the use of a four-legged cane. She still uses these mechanical aids. She is able to give herself the passive exercises needed to keep the involved extremities pliable. Maximum benefit has been reached. The health aide's visits were reduced according to the progress made by the patient. Currently, she is visited every two weeks by the health aide only for assistance with occupational therapy.

It is the opinion of the team that the health aide was an important person in the rehabilitation program of this patient. The patient, as a result, is able to function independently.

2. *Case History* *Admitted:* 4-1-66
Status: Active

Background Information–Mr. C is a 63-year-old male with a diagnosis of paralysis due to myelitis or spinal artery thrombosis. He was accepted on the Home Care Program on April 1, 1966.

Social and Health Problems – Mr. C lives with his sister, age 68; an invalid brother-in-law, age 79; cousins and nieces. Patient has his own room on the first floor of a two-story house. He is confined to bed or a wheelchair, requiring assistance with bathing his back, lower extremities and transfer activities. He must be changed frequently due to incontinence. In addition to giving her brother care, the sister also cares for her husband. However, she too, has a heart condition with certain physical limitations.

Mr. C is very dependent. He is the youngest member of his family and never severed the dependent ties to his mother even after adulthood and marriage. This same dependence has been transferred to his sister who is now in the role of mother substitute.

It was recommended by the team that a health aide be assigned to assist in the needed areas of physical therapy and personal care.

Summary of Sequence of Events–This patient was first evaluated on April 21, 1966. At that time, he had considerable motor function in the right lower extremity. One week later he was able to demonstrate slight motor return in the left lower extremity.

The following week, the health aide and the patient were instructed in the physical therapy program which included passive and active assistive exercises for all range of motion of the lower extremities, resistive exercises, and other instructions.

At this time the ultimate goal for this patient was crutch walking with a long leg brace on left lower extremity. The health aide visited four times a week.

Patient progressed nicely until a CVA in May 1966. Patient suffered complete loss of motor function in the lower extremities, impairment of balance, some loss of strength in the upper extremities, etc.

The physical therapy program and goals were revised. Since the goal, at that time, had to be one of wheelchair existence for the patient, the physical therapy program was amended to stress strengthening of depressor muscles of the upper extremities and transfer activities.

The health aide worked diligently with the patient until he was able to transfer from bed to chair and back unassisted. He also learned to roll his wheelchair into the kitchen, bathe himself with the exception of his back and feet, do his exercises (for the lower extremities) unassisted, dress himself in pajamas, etc.

At this time, the health aide was no longer needed for physical therapy follow-up. However, we found that neither the patient nor family followed through on the program he had learned.

The heath aide has since been sent back into this home three times a week to help patient transfer to wheelchair and back to bed.

Suggested Career Mobility for Community/Home Health Aides

The Need for Realistic Career Mobility

The New Careers training model provides a new way to help people bridge the gap between lack of credentials in a human service occupation and job entry with potential career mobility. Career mobility means not only opportunities for initial training and employment but also for succeeding steps leading to a desired career.

Opening up careers, rather than jobs, is the key distinction between the New Careers training model and other job training programs. "It is important to distinguish between job-oriented training and career-oriented training." [3] Job training connotes training for positions that may or may not be permanent. Career training implies progress through clearly defined steps, each with carefully stated requirements for further progress. Job training, especially for people without a high school diploma, generally means a dead-end job, a job with no hope and usually little dignity. Career training screens people *into* programs and, while they are in training, helps them achieve high school equivalency diplomas or other academic certificates.

Human service agencies must recognize that the quality of their service is improved through the unique contributions of indigenous human service aides. Agencies have a responsibility to encourage and assist their aides in realizing true career mobility in the same way they do for professional staff. Using human service aides makes good sense for health agencies. The shortage of health manpower is increasing the gap between the level of health care now possible and the continued unmet health needs of the public, particularly residents in urban slums and poverty pockets in suburban and rural communities.

"A significant answer to this complex problem has been the development of experimental programs for the training and employment of local residents in jobs with career possibilities in community health service programs." [4] A number of training centers and health service agencies throughout the country have developed entry-level positions in a variety of health-related occupations and have successfully trained and employed undereducated, underemployed, and unemployed people for those positions. Some have also developed career ladders and the necessary supportive training to encourage and facilitate upward and diagonal mobility beyond the entry level. Training programs have been conducted for careers as home health aides, health education aides, mental health aides, physical therapy aides, recreational therapy aides, and others.

The New Careers training model has demonstrated its potential for training health and mental health aides. The placement of graduates of these programs marks the first time that undereducated, unemployed, and underemployed people have been helped to the first step in career mobility.

Many health service agencies have successfully utilized health aides for a number of years. For example, home health aides function out of public and private nonprofit agencies in California and provide direct patient service to the chronically ill, the geriatric and handicapped patient. In the District of Columbia a broad variety of human service aides in health and mental health have been trained and assigned to public agencies. In Pittsburgh and New York City, aides work in public and private agencies as neighborhood or community health aides. The aides are trained in carefully planned and supervised programs and receive comprehensive on-the-job experience. In most cases, remedial education parallels the training program. The early experiences reported by the agencies employing New Careerists have demonstrated that this concept is viable and realistic.

The critical question now is not, "Should we use people indigenous to poverty areas to fill health needs?" but rather, "How quickly can we do so?" Schaefer and Hilleboe[5] suggest that "the choice has ceased to be whether or not the order of public health will change in the way it conceived of its mission and of the administrative problems to be solved. The choice is whether coming changes will be thrust upon community health agencies ill prepared to absorb them or adapt them, or whether organized health agencies will seize their opportunities, through farsighted planning, and influence the shape of the future."

Career Ladders for Community/Home Health Aide Occupations

Career mobility is the main underlying concept of the New Careers program. The attainment of the necessary skills and knowledge that enable a person to adequately function as a health aide is the beginning of a series of steps on the career ladder.

Once a person has gained proficiency in performing the duties of either the community or home health aide, there are two positions to which he might advance: senior health aide and supervisory health aide.

The functions and duties that can be assumed by a *senior health aide* are as follows:

1. Work closely with new health aides, providing support and making suggestions that will facilitate their learning process.
2. In the absence of the health aide supervisor and the supervisory health aide, the senior health aide can make temporary assignments for emergency cases that involve accompanying a person to a health facility, and can stay with relatives while other family members attend a health facility.
3. In community organization projects, the senior aides can be responsible for coordinating the activites of other health aides and volunteers.
4. He can keep accurate records on the progress of the community organization team which he coordinates.
5. He can assume the leadership role of a group of health aides who are developing pamphlets or other educational materials on health subjects.
6. He can accept speaking engagements after necessary clearances in instances when another agency or group wishes to utilize the services of an indigenous health worker.

Aides who demonstrate exceptional ability and/or show evidence of continued education could be delegated these additional functions:

7. Keeping accurate reports for special projects.
8. Under the close supervision of the supervisor or supervisory health aide, reviewing records of other health aides and making suggestions of additional ways in which the recording could be improved.
9. Discussing family situations with other health aides and suggesting ways some of the obstacles they have encountered could be overcome.
10. Assuming leadership role in group conferences.

After additional experience and the demonstration of capacity for supervisory responsibility, the senior health aide can assume these duties of a *supervisory health aide:*

1. Assigning cases to health aides.
2. Providing direct guidance to health aides regarding all aspects of providing care to families and patients. In areas where professional assistance is required, the supervisory health aide is expected to recognize the need and make arrangements for it.
3. Assisting health aides in planning and implementing community organization projects.
4. Assisting in providing instruction to new health aide recruits.
5. Evaluating the performance of their supervisees.

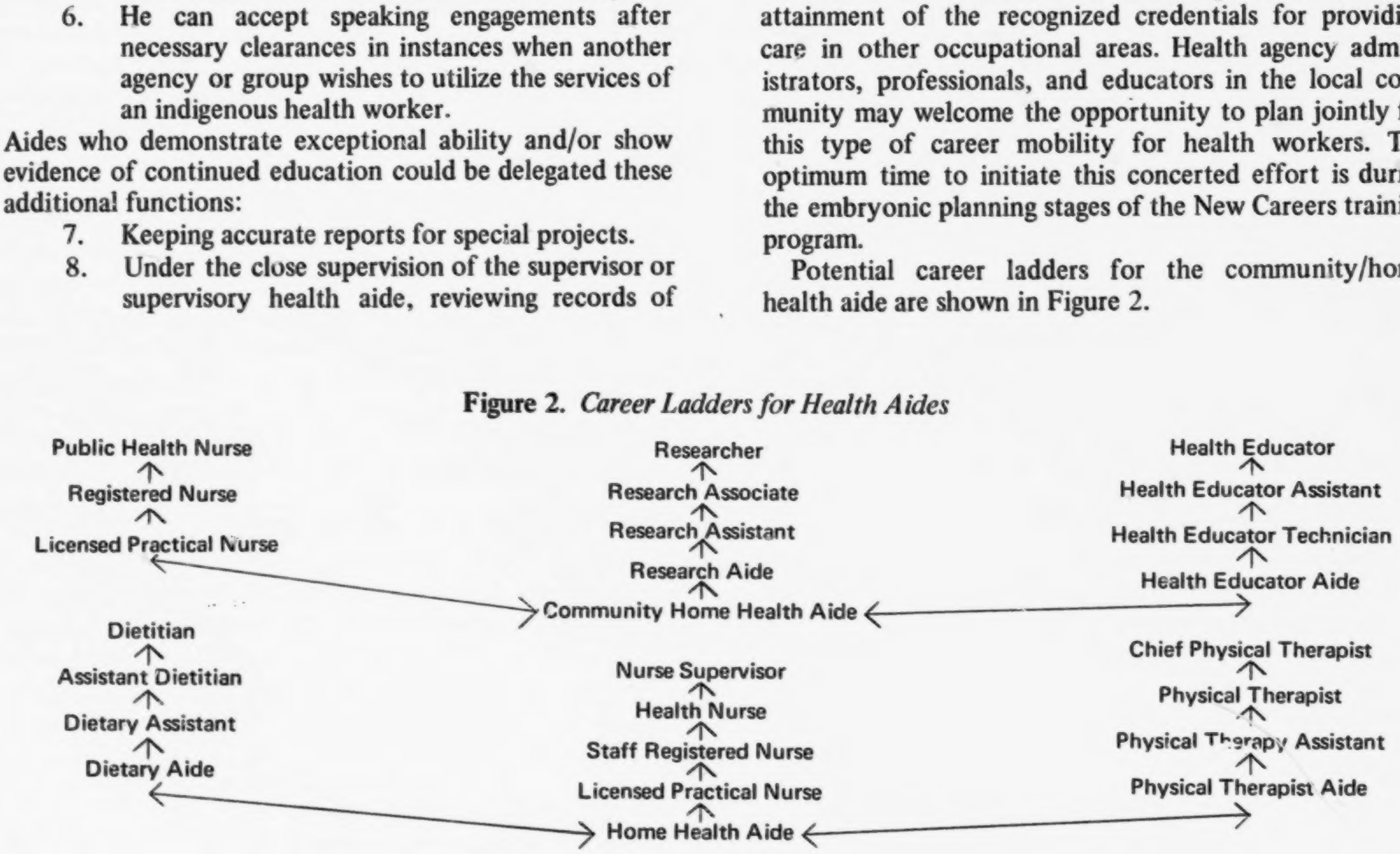
Other Potential Career Ladders for Community/Home Health Aides

Some health aides may have an interest in career advancement outside the health aide occupation. There are numerous avenues open following additional training and/or education.

The rationale of New Careers training necessitates preplanning for those persons who aspire to more challenging occupations and professions in the health field. Early communication with technical schools, junior colleges, colleges, and health agencies that provide training will provide New Careers administrators with knowledge relative to the academic and skill requirements for the attainment of the recognized credentials for providing care in other occupational areas. Health agency administrators, professionals, and educators in the local community may welcome the opportunity to plan jointly for this type of career mobility for health workers. The optimum time to initiate this concerted effort is during the embryonic planning stages of the New Careers training program.

Potential career ladders for the community/home health aide are shown in Figure 2.

Figure 2. *Career Ladders for Health Aides*


Public Health Nurse
Registered Nurse
Licensed Practical Nurse
Researcher
Research Associate
Research Assistant
Research Aide
Community Home Health Aide
Health Educator
Health Educator Assistant
Health Educator Technician
Health Educator Aide
Dietitian
Assistant Dietitian
Dietary Assistant
Dietary Aide
Nurse Supervisor
Health Nurse
Staff Registered Nurse
Licensed Practical Nurse
Home Health Aide
Chief Physical Therapist
Physical Therapist
Physical Therapy Assistant
Physical Therapist Aide

II. TYPICAL PROBLEMS AND RECOMMENDED SOLUTIONS IN COMMUNITY/HOME HEALTH AIDE TRAINING PROGRAMS

The problems encountered in establishing a training program to prepare educationally disadvantaged persons to assume responsible positions as health service aides will require considerable attention by the New Careers training program director.

The problems most likely to arise can be related to three main issues: (l) initiation of the training program; (2) the relationship between the trainer and the health service aide trainee; and (3) relationships between the health service aide trainees and the recipients of the service.

Initiation of the Training Program

Prior to initiating a New Careers training program for community/home health aides, the employing health agency administrator and staff must accept the concept and role of the health service aide. Such a role has not been incorporated into traditional patterns for the delivery of health services. Acceptance of the philosophy that a health service aide can improve the quality of health care provided by the health team is an important prerequisite to the reorganization of the staffing pattern and re-evaluation of the role each member assumes on the health team. It is desirable to re-evaluate functions of all health personnel before initiation of a community/home health aide training program in order to determine the most efficient utilization of all health personnel within the agency. Moreover, this re-evaluation of roles and functions should provide the beginning step for job development as it relates to the health service aide.

All levels of staff in the employing health agency must be oriented to New Careers training concepts and objectives to ensure that staff members fully understand the rationale of this innovative training program. Involvement of all levels of staff in planning for the training program, job development for the health service aide, implementation of the training program, and the entrance on duty of the health service aide are essential to attain the overall objectives of a New Careers program.

Relationships Between the Trainer and Health Service Aide

As envisioned in the New Careers training model, trainees will be exposed simultaneously to all training components (generic issues, basic health training, skill training and on-the-job training).

Trainers must be aware of and appreciate the unique attributes the health aide brings to the health service team. Also, each trainer should appreciate the function of other trainers in the overall training model. Good interrelationships between the trainers and the individual trainees will go far in fostering a comprehensive, innovative training program geared to providing knowledge and skills to the economically and educationally disadvantaged in the local community.

A clear definition of the responsibilities of the trainer for each component should be developed jointly by all concerned during the early planning phase. In some instances, one person may assume responsibilities for more than one component depending upon the decisions made for implementation of the individual training program.

At the beginning of the program, trainees must be oriented to the three components of the training model and must have a clear understanding of the interrelations between the components and the trainers. This will prevent any confusion and conflict that might arise among the supervisors of the three components and the trainees.

Relationships Between the Health Service Aide Trainee and the Recipient of the Service

Because most of the trainees will be indigenous to the immediate area to be served, programs arising from the dual role of a friend or enemy and a person in the helping role may require preventive measures and, in some instances, solutions.

Extraneous circumstances may have a bearing on the desirability of an assignment to a specific trainee. When a prospective patient or family is known to the trainee, the trainee should help decide whether he should be assigned the case. The trainee is in the best position to know all of the ramifications of a previous association with a neighbor. Moreover, an inappropriate assignment may have far-reaching effects on the acceptability of the training program and the job development of the community/home health aide in the local community and employing health agency.

The recipients of the service can be the most effective supporters of the programs. Consequently, it is vitally important to prepare all trainees for the initial home visit. A proper introduction will include the name of the trainee, his position and the agency he represents. Each trainee should explain to the family and patient the purpose of the visit.

During the visit the trainee should remember that he is a guest in the home and should behave accordingly. If problems arise between the trainees and the patient or family, corrective measures should be instituted without delay. The health aide is in a good position to make a judgment regarding the transfer of the case to a co-worker. As far as possible, steps should be taken to effect a solution that will enable the trainee to retain the case. If these attempts fail, the case should be reassigned in a manner that is agreeable to the patient, family and the trainee.

III. ORGANIZATION AND STRUCTURE OF THE PROGRAM

The New Careers training model consists of a number of related elements – job development; daily small-group discussions focused on human service and job issues; remediation and/or basic education; skill training; on-the-job training, and weekly seminars for supervisory personnel in these training elements.[6] The planning and organization of any New Careers program should incorporate these elements and their related curriculum cores.

Rationale for Curriculum and Content "Cores"

Elements common to all human service areas such as education, welfare, health, and law enforcement, comprise the basic content of the first generic core curriculum.[7] They include perspectives on poverty; human development and problems of people, common psychopathology, major problems in the delivery of human services, the use of community resources for the resolution of human problems, consumer education, the world of work, minority group history, prejudice, field trips to representative human service agencies, interviewing, communication, and remediation.

In addition to the generic core curriculum in human services, there is a similar "sub-core" in health, which includes the study of the organization of health services and basic information about health, disease and the human body. To prepare enrollees for a wide variety of entry-level health occupations, they should all be exposed to this basic health curriculum prior to or along with specific skill training. The progression of the curriculum can be illustrated as follows:

Figure 3. *The Progression of Curriculum Areas New Careers Training Model*

		Specific entry job-skill training
Generic Issues in Human Service Occupations	Basic Curriculum for Health	Community/Home Health Aide, Nurse Aide, etc.
	Basic Curriculum for Education	Library Aide, Teacher-Aide, etc.
	Basic Curriculum for Social Service	Case Work Aide, Community Service Aide, etc.
	Basic Curriculum for Justice	Community Relations Aide, Patrolman's Aide, etc.

Planning the curriculum for human service aides in this manner ensures the greatest possible flexibility in the initial phase of training by providing all enrollees with a common base of information and experiences which can be built upon in subsequent curriculum areas. It also prevents the necessity of an enrollee repeating the entire training cycle if he or the training team decides that his initial choice of entry-level occupation was inappropriate. If a trainee completes the generic and health curriculum and is in the final stage of training as a community/home health aide, at which time the decision is made that this is not the appropriate area of occupation for him, only the skill portion of training needs to be repeated in another area, such as laboratory aide. The same is true for any stage of training or human service occupational area.

As trainees in their small groups bring up issues and problems, these can be related to the broader aspects of information to be presented in the units outlined in the generic core curriculum for human services. For example, if one of the trainees reports the arrest of a friend, core group discussion could focus on the relationship of the police department to the community. If a health problem is brought up, personal and/or environmental health can be discussed as it relates to the community in which the trainees live.

The content of the skill workshops should be worked out jointly with the health agency at the time specific vacancies for which the trainees will be employed are defined.

The New Careers training staff should take responsibility for coordinating the training, leading the core group, and providing the remedial support to the program. The health agency should take responsibilities for the job supervision and the skill and basic health training. The New Careers staff should provide consultation of these two components as necessary.

Salient Points to Stress During Training

A number of points will need to be repeated throughout the training program. These generally relate to proscriptions of a legal and policy nature or information concerning the agency in which the aide is training and will be an employee. The agency supervisor responsible for coordinating the skill and on-the-job training may wish to add other points in addition to these:

1. All information that comes to the knowledge of the health aide during the performance of his duty is confidential.
2. When working with a family with which the staff public health nurse is also working, the responsibility for the quality of the total nursing care given to the patient rests with the professional nurse.
3. Effective communication among all workers involved with the family is essential.
4. At no time will a health aide suggest that an individual or a family use any type of medicine. It should be carefully explained that such action is treatment of disease and is never to be done by an aide or a nurse. *There are no exceptions to this rule.*
5. At no time will a health aide suggest that an individual or a family has any type of illness, no matter how minor. It should be carefully explained that such action is diagnosing and is never to be done by an aide or a nurse. *There are no exceptions to this rule.*
6. His responsibilities to the agency and the necessity of keeping within the limitations of the agency policies should be explained to the health aide.
7. The aide should have an understanding of the total organizational structure of the parent agency.
8. The role of all departments in the parent agency and of health aides within them should be discussed.
9. The health aide may have to carry out many of his functions informally during hours other than the usual daily schedule.

It is anticipated that once a person is recognized as a health aide in the community, neighbors will call upon him to seek advice during evening hours and the weekend. This aspect of the operation should be encouraged and the health aide should be told that the hours of employment are flexible and he is to be available when needed. Supervision also should be available to the aide during evening hours and weekends by telephone. If such arrangements cannot be made, then the program should *not* operate on a flexible basis. Compensatory time should be extended when the aide works evening hours and weekends.

Articulation of Program Components

The three components of this training process – the Basic Health Curriculum, Community Health Aide Specialty Area, and the Home Health Aide Specialty Area – are designed to be related to the other components of the New Careers training model discussed earlier. To reiterate, one of the basic concepts of the New Careers program is that all training components should begin and be conducted simultaneously. Following this concept, then, the daily training schedule for health aides will be:

Community Health Aide (CHA)
2 hours – Basic Health and CHA Skill Training
4 hours – Community Health Aide OJT
2 hours – Generic Core Curriculum

Home Health Aide (HHA)
2 hours – Basic Health and HHA Skill Training
4 hours – Home Health Aide OJT
2 hours – Generic Core Curriculum

The entire training course should cover a period of six months. Content taught in the generic core, basic health and skill training sessions will relate to the types of experiences gained from the on-the-job component. Careful scheduling will enable the trainer to proceed with a more practical approach in teaching the theoretical and skill elements of the training course.

A daily plan necessitates a flexible course outline. For example, the health agency that is providing the experience for the trainees may sponsor a mass immunization drive against measles and polio. The community health aide trainer sees this drive as an excellent opportunity to involve the trainees in a community organization effort. Instead of teaching the trainees the procedures for participating in an interdisciplinary conference, the trainer covers the skill area of community organization and the health core of infectious diseases to prepare the trainees for new activity.

To facilitate the shifting of curriculum and skill area content, the unit method of curriculum development as used in this manual should be adopted. The job situation determines the amount of time and the content area to be presented during the training course; therefore, it is essential that the overall training course be adaptable and allow for alterations in the scheduling of specific elements.

Development of Curriculum

As was just mentioned, the unit plan was utilized in the development of the overall training guide and the accompanying curriculum manuals for trainees. The anticipated outcomes, or the job functions, were examined for the type of knowledge and skill necessary to enable the health aide to provide adequate and safe care to the patient. An overall *objective* that states the expected learning outcome was established for each unit. Specific *objectives* that comprise component parts of the overall objective are stated in the unit plan. Following the statements of specific objectives, the *content* essential to the accomplishment of the objectives is developed.

The content area represents a skeletal outline of the specific knowledge and skills necessary to the attainment of outcome goals. As the curriculum unfolds, the trainer should supplement the material presented in this manual with additional elements. The depth toward which the trainer will strive will depend upon the ability of the trainees to comprehend the material, the needs and interests of the trainees, and the demands of the job situation. The trainees should share responsibility for providing additional content to be taught. It is essential that the supplemental elements be closely related to the functions of the aides. Teaching activities are suggested for each specific learning objective. The activities are not meant to limit the creativity of the trainer; on the contrary, the activities are suggestions *only* and it is expected that the trainer will use imagination, and gear the types of activities to the needs and interests of the trainees, the equipment and facilities available in the local community, the needs of the patients, and the individual personality that he possesses.

As alterations are made in the curriculum, the trainer should accurately record the changes and keep a permanent record of them. It is through the supplemental material that the goal will be realized of providing the necessary knowledge and skills to prepare the New Careerist to conform adequately to a health service role that meets his own needs, the needs of the patient, and the needs of the health service agency.

Scheduling

The New Careers training program emphasizes the need for the trainee to experience anxiety conducive to learning and meaningful success at various intervals during the training period. This principle is reflected in the course content by the inclusion of frequent examination and recapitulation sessions.

The examinations may take the form of "return" demonstrations of a specific skill, an oral or written examination in the classroom, structured observation during a group teaching activity, self evaluation of a community organization project, and other creative measures that will afford the opportunity for the New Careerist to obtain the feeling that he has obtained a meaningful goal.

The recapitulation periods will enable the trainer to re-emphasize those areas that present difficulty as evidenced by the results of the examinations. If possible, the trainees are to assume major responsibility for assisting other trainees in increasing their knowledge and skill during the recapitulation sessions. This type of activity, New Careerists helping each other, will enhance the abilities of all trainees in developing techniques for providing instruction to their patients.

The scheduling of the entire training course is predicated on the idea that one learns by doing. This concept is particularly relevant with respect to the types of skills to be taught, the shortage of health manpower, and the needs of the service agency. The great emphasis placed on the on-the-job training component reflects the basic belief in learning by performing.

The six-months training period contains a total of 24 weeks or 960 hours. The time allocated for the various components is:

480	On-the-Job Training
240	Health Aide Skill and Basic Health Training
240	Generic Core Curriculum
960	Total Hours

The community health aide and the home health aide should be taught the basic health curriculum during the same sessions. The specialty areas should be taught in separate sessions for each type of trainee and in the settings most appropriate for the specific skill.

In addition to the classroom/laboratory activities, the health aides should participate in periodic training seminars. The purpose of the seminars will be to bridge the gap between the on-the-job training component and the basic health/skill component.

The major technique to be used in the home health aide training seminar is the *case presentation method*. In this approach, one or two health aides will describe a patient who has received care during the previous two weeks. The suggested format of the presentation is as follows:

1. *Identifying Data*
    a. Patient's name
    b. Age
    c. Address
    d. Sex
    e. Referral source
    f. Doctor's name
2. *Health Problems*
    a. Diagnosis(es)
    b. Disabilities
    c. Limitations
    d. Areas of need
3. *Total Care Plan*
    a. Doctor's orders
    b. Public health nurse's care plan
    c. Occupational/physical therapy
    d. Other care
4. *Home Health Aide Care Plan*
    a. Needs
    b. Bedside care
    c. Other care
5. *Areas of Need: Examples*
    a. Unmet health needs
    b. Ineffective communication among workers
    c. Problems of family
    d. Inadequate equipment in the home

During the home health aide training seminar, the trainees can engage in problem-solving activities regarding a patient or a general problem. Information sharing and collective solutions will be encouraged by the trainer. It is anticipated that the seminar will lead to improved patient-care techniques.

Suggested Approach to Scheduling

The 24-week schedule which follows is not intended to be used exactly as outlined. It represents a suggested approach to the organization of the learning process and the integration of the complementary parts of the New Careers training program. We recognize that no two training programs will be the same nor will the same subjects be taught on the same problem on precisely the same day and the same time.

The "Suggested Approach to Scheduling" should be adopted as the program develops. We suggest the trainer note very carefully on the appropriate day and time the specific content and skills taught in the development of the given individual training program as a future guide in program planning.

SUGGESTED WEEKLY SCHEDULE FOR THE COMMUNITY HEALTH AIDE

E = Examination

R = Recapitulation

Week No. 1:

8:30 – 9:30	Mon. – Tues.:	IV.	A.	Health Service Aide
	Wed.:	IV.	B.	Biological Concepts
	Thurs.:	IV.	B.	Biological Concepts (R)
	Fri.:			Seminar
9:30 – 10:30	Mon.:	IV.	A.	Health Service Aide
	Tues. – Wed.:	IV.	B.	Biological Concepts
	Thurs.:	IV.	A.	Health Service Aide
	Fri.:			Seminar

Week No. 2:

8:30 – 9:30	Mon. – Tues.:	VI.	A.	Family
	Wed. – Thurs.:	VI.	B.	Family Health Needs
	Fri.:	IV.	C.	Professionals in the Health Field
9:30 –10:30	Mon.:	VI.	A.	Family
	Tues.:	VI.	A.	Family (R)
	Wed.:	VI.	B.	Family Health Needs
	Thurs.:	VI.	B.	Family Health Needs (E) (R)
	Fri.:	IV.	C.	Professionals in the Health Field

Week No. 3:

8:30 – 10:30	Mon.:	IV.	C.	Professionals in the Health Field
	Tues. – Wed.:	VI.	D.	Community Resources
	Thurs.:	VI.	G.	Eligibility Requirements for Community Health Services
	Fri.:			Seminar

Week No. 4:

8:30 – 9:30	Mon.:	VI.	G.	Eligibility Requirements for Community Health Services
	Tues. – Wed.:	VI.	F.	Referrals
	Thurs. – Fri.:	IV.	N.	Interviewing Skills

9:30 – 10:30	Mon.:	VI.	G.	Eligibility Requirements for Community Health Services (E) (R)
	Tues. – Wed.:	VI.	F.	Referrals
	Thurs. – Fri.:	IV.	N.	Interviewing Skills
Week No. 5:				
8:30 – 9:30	Mon. – Thurs.:	IV.	E.	Human Body
	Fri.:			Seminar
9:30 – 10:30	Mon. –Thurs.:	IV.	E.	Human Body
	Fri.:			Seminar
Week No. 6:				
8:30 – 9:30	Mon. – Fri.:	IV.	E.	Human Body
9:30– 10:30	Mon. – Fri.:	IV.	E.	Human Body
Week No. 7:				
8:30 – 9:30	Mon.:	IV.	E.	Human Body (E)
	Tues. – Wed.:	VI.	C.	Community Health Problems and Needs
	Thurs.:	IV.	O.	Recording Skills
	Fri.:			Seminar
9:30 – 10:30	Mon.:	IV.	E.	Human Body (R)
	Tues. – Wed.:	VI.	C.	Community Health Problems and Needs
	Fri.:			Seminar
Week No. 8:				
8:30 – 10:30	Mon.:	IV.	O.	Recording Skills
	Tues. – Fri.:	IV.	K.	Selected Chronic Diseases
Week No. 9:				
8:30 – 9:30	Mon.:	IV.	K.	Selected Chronic Diseases (E)
	Tues. – Thurs.:	IV.	L.	Infectious Diseases
	Fri.:			Seminar
9:30 – 10:30	Mon.:	IV.	K.	Selected Chronic Diseases
	Tues.–Thurs.:	IV.	L.	Infectious Diseases
	Fri.:			Seminar

Week No. 10:

8:30 – 9:30	Mon. – Tues.:	IV.	L.	Infectious Diseases
	Wed. – Fri.:	VI.	J.	Interdisciplinary Conferences
9:30 – 10:30	Mon.–Tues.:	IV.	L.	Infectious Diseases
	Wed. – Thurs.:	VI.	J.	Interdisciplinary Conferences
	Fri.:	VI.	J.	Interdisciplinary Conferences (R)

Week No. 11:

8:30 – 9:30	Mon. – Tues.:	IV.	F.	Conception, Gestational Development, and Contraception
	Wed. – Thurs.:	IV.	G.	Growth and Development
	Fri.:			Seminar
9:30 – 10:30	Mon.:	IV.	F.	Conception, Gestational Development, and Contraception
	Tues.:	IV.	F.	Conception, Gestational Development and Contraception
	Wed. – Thurs.:	IV.	G.	Growth and Development
	Fri.:			Seminar

Week No. 12:

8:30 – 9:30	Mon.:	IV.	G.	Growth and Development
	Tues.:	IV.	G.	Growth and Development (E)
	Wed. – Thurs.:	VI.	H.	Accompanying Patients to Community Health Services
	Fri.:	VI.	I.	Care of Other Family Members
9:30 – 10:30	Mon.:	IV.	G.	Growth and Development
	Tues.:	IV.	G.	Growth and Development (R)
	Wed. – Thurs.:	VI.	H.	Accompanying Patients to Community Health Services
	Fri.:	VI.	I.	Care of Other Family Members

Week No. 13:

8:30 – 10:30	Mon.:	VI.	I.	Care of Other Family Members
	Tues. – Thurs.:	VI.	L.	Group Teaching
	Fri.:			Seminar

Week No. 14:

8:30 – 10:30	Mon.:	VI.	D.	Community Resources
	Tues. – Wed.:	IV.	N.	Interviewing Skills
	Thurs. – Fri.:	IV.	H.	Nutrition

Week No. 15:

8:30 – 10:30	Mon. – Thurs.:	IV.	H.	Nutrition
	Fri.:			Seminar

Week No. 16:

8:30 – 9:30	Mon. – Tues.:	IV.	H.	Nutrition
	Wed. – Thurs.:	IV.	D.	Public Health Administration
	Fri.:	VI.	D.	Community Resources
9:30 – 10:30	Mon.–Thurs.:	IV.	D.	Public Health Administration
	Fri.:	VI.	D.	Community Resources

Week No. 17:

8:30 – 10:30	Mon. – Tues.:	VI.	D.	Community Resources
	Wed. – Thurs.:	VI.	E.	Environmental Health and Home Sanitation
	Fri.:			Seminar

Week No. 18:

8:30 – 10:30	Mon. – Tues.:	VI.	E.	Environmental Health and Home Sanitation
	Wed. – Fri.:	VI.	K.	Community Organization

Week No. 19:

8:30 – 10:30	Mon. – Wed.:	VI.	K.	Community Organization
	Thurs.:	VI.	D.	Community Resources
	Fri.:			Seminar

Week No. 20:

8:30 – 10:30	Mon.:	VI.	D.	Community Resources
	Tues. – Wed.:	VI.	M.	Working with Other Persons in the Helping Role
	Thurs. – Fri.:	VI.	C.	Community Health Problems and Needs

Week No. 21:

8:30 – 9:30	Mon. – Tues.:	IV.	O.	Recording Skills
	Wed. – Thurs.:	IV.	I.	Accidents
	Fri.:			Seminar
9:30 – 10:30	Mon.:	IV.	O.	Recording Skills
	Tues.:	IV.	O.	Recording Skills (R)
	Wed. – Thurs.:	IV.	I.	Accidents
	Fri.:			Seminar

Week No. 22:

8:30 – 9:30	Mon. – Tues.:	IV.	J.	Epidemiology
	Wed. – Fri.:	IV.	M.	First Aid
9:30 – 10:30	Mon.:	IV.	J.	Epidemiology
	Tues.:	IV.	J.	Epidemiology (R)
	Wed. – Fri.:	IV.	M.	First Aid

Week No. 23:

8:30 – 10:30	Mon. – Thurs.:	IV.	M.	First Aid
	Fri.:			Seminar

Week No. 24:

8:30 – 10:30	Mon. – Wed.:	IV.	M.	First Aid
	Thurs. – Fri.:	IV.	P.	Evaluation

TYPICAL WEEKLY SCHEDULE

Hour:	Monday	Tuesday	Wednesday	Thursday	Friday
8:30 - 9:30		**SPECIAL SKILL TRAINING**			
9:30 - 10:30		**(See suggested schedule on the preceding pages.)**			
10:30 - 12:30		ON-THE-JOB TRAINING			
12:30 - 1:00		LUNCH			
1:00 - 3:00		ON-THE-JOB TRAINING			
3:00 - 5:00		GENERIC ISSUES (THE CORE GROUP)			

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15. Grosser, Charles. *The Role of the Nonprofessional in the Manpower Development Programs.* Washington, D. C.: U.S. Department of Labor, Manpower Administration, Office of Manpower Policy, Evaluation and Research.

16. Jones, James A. *Research in Experimental and Demonstration Programs for Disadvantaged Youth.* Washington, D. C.: U.S. Department of Labor, Manpower Administration, Office of Manpower Policy, Evaluation and Research, 1967.

17. Sexton, Patricia C. *The Basic Education Component of Experimental and Demonstration Projects (E&D) for Disadvantaged Youths.* Washington, D.C.: U.S. Department of Labor, Office of Manpower Administration and Training, Division of Special Programs, 1967.

CHAPTER IV

BASIC HEALTH CURRICULUM

Chapters IV through VI are keyed to the three
sections of *The Community/Home Health Aide Trainee's Manual*

A. THE HEALTH SERVICE AIDE

Overall Objective:

To gain an understanding of the role of the Health Service Aide.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To gain an understanding of the need for human service aides in the health fields.	1. *Need for Human Service Aides* a. Inadequate number of professionals to meet demand. b. All tasks now assumed by professionals do not require their skills. c. Many tasks now assumed by professional can be done more skillfully by another type of worker. d. Better economics. e. Better utilization of skills of various levels of staff. f. More jobs made available for unemployed and underemployed.	1. General discussion. Active involvement of trainees. Trainees discuss experiences in health service jobs. Discuss own contact with health service aides and professionals. Discuss where satisfied and unsatisfied with service.
2. To gain an understanding of the types of subprofessionals in the health fields.	2. *Selected Health Service Aides* *Hospital* a. Orderly– male; assists nurse; works primarily with male patients. b. Nurse aide– female; assists nurse; works with both female and male patients; gives bedside care. c. Dietary aide–assists in preparing special and regular diets, serving meals, and handling meal lists submitted by patients. d. Other specialty aides – x-ray, EKG, surgical, physical therapy, etc.; assists the professional in the specialty area; male or female; works in prescribed areas only; varies with each setting. *Public Health* a. Clinic aide – assists in Well Baby Clinic, Maternity Clinic, Chronic Disease Clinic, etc.; assists physician and nurse; keeps records, weighs patients; assists in preparing patients for examinations. b. Health Education Aide–assists the professional health educator in explaining health department programs to the community.	2. General discussion.

c. Home Health Aide – gives bedside care in the home under the general direction of a public health nurse or other professional.

d. Community Health Aide – gives health instructions and encourages the patient to obtain the necessary health care.

HOME HEALTH AIDE DUTIES

1. Takes and records temperature, pulse, and respirations.
2. Takes blood pressure.
3. Makes beds, occupied and unoccupied.
4. Changes uncomplicated dressings.
5. Places bedpan and urinals, cleans utensils following use.
6. Assists ambulatory patients with bath; assists others with partial bath.
7. Gives complete bed baths.
8. Combs hair, dresses patient, and assists with other personal care when necessary.
9. Reminds patient to take prescribed medications under guidance of nurse and/or physician.
10. Prepares meals for patient and feeds them when necessary.
11. Performs simple treatments (enemas, range of motion exercises, assistance with cane and crutch walking, massages, provides special skin care).
12. Assists with or performs mouth care.
13. Provides diet instructions to patient and family.
14. Informs health aide supervisor of progress or deterioration of the patient. Informs staff public health nurse of significant changes and the patient's response to care.
15. Keeps accurate reports of care given and significant findings during the course of caring for the patient.
16. Participates in team conferences with professional staff.
17. Recommends ways of improving care given to the patient in the home.
18. Accompanies patients to the health service when necessary.
19. Performs light housekeeping duties consistent with providing a therapeutic environment.

20. After the physical therapist or nurse instructs the patient to carry out housekeeping duties within the limits of his disease, the health aide can reinforce this teaching when assigned.

COMMUNITY HEALTH AIDE DUTIES

1. Motivates patients and families – giving support, showing interest, conveying understanding, maintaining a friendly relationship, and using other neighborly techniques – to seek health care.
2. Interprets the importance of seeking preventive care and early treatment of disease.
3. Gives instructions to individuals in the home and in groups regarding primary prevention (all those measures that promote health. Examples: proper nutrition, good personal hygiene, good housekeeping practices, proper rest, adequate ventilation, adequate exercise, etc.).
4. Evaluates health needs of each family member under close supervision of the health aide supervisor. (Examples of health needs in a family: prenatal care; eye care and dental work; physical examination; follow-up for known diabetic condition; child health supervision; evaluation for apparent mental retardation.)
5. Determines health need priorities and a plan of care under the close supervision of the health aide supervisor.
6. Informs family of the available health facilities that could meet their specific needs.
7. Interprets eligibility requirements of various health facilities.
8. Makes referrals to appropriate health agencies in following through on the care plan; follows through on referrals to determine if the patient has actually obtained the service to which he was referred.
9. Accompanies patient to facility when necessary.
10. Stays with children or elderly relatives while other family members attend health facility.
11. Reports to public health nurse, social worker, medical doctor, and other professionals significant findings in relation to health and social matters observed.
12. When asked, reinforces instructions given by the professional and encourages patient to carry out orders.
13. Casefinding – discovers persons in neighborhood who have untreated health problems and initiates action to correct this situation.

OBJECTIVES	CONTENT	ACTIVITIES
	14. Keeps an accurate record of contacts with families and the services rendered. 15. Initiates, organizes, and implements group classes under the supervision of the health aide supervisor. 16. Initiates, organizes, and implements community organization projects geared to motivate large numbers of persons to avail themselves of health services and health innovations. 17. Teaches the family sound housekeeping practices, accident prevention, good nutritional habits, and personal hygiene. 18. Performs some housekeeping duties while staying with children or elderly relatives while other members of the family attend a health facility. This most often involves preparing food and dressing infants and preschoolers. 19. Performs first aid measures when the situation presents itself. 20. Develops health literature on the level of the people it is expected to reach. This activity is performed with the advice and support of professional health educators who specialize in the development of literature. 21. Participates in team conferences with professional staff in regard to individual families.	
3. To gain an appreciation of the role of the Health Service Aide.	3. *Appreciation of the Role of the Health Service Aide* (HSA) a. The HSA has an important contribution to make in the overall care plan for the individual, family, and community. b. The HSA shares a common background with the recipient of the service. This increases his effectiveness in communicating with and understanding those he serves. c. The HSA can serve as the liaison between the family and the professional. d. The HSA can interpret community behavior and language patterns to the professional. e. The HSA can greatly increase the effectiveness of the more traditional methods for providing health care to the community.	3. The trainer will discuss with the trainees the contribution that a Health Service Aide can make. The trainer is to be very supportive, reinforcing positive responses and statements from the trainees. The trainer is to mention points only when necessary to keep the discussion going.

References on the Role of the Human Service Aide

1. Grant, Joan, "The Industry of Discovery: New Roles for the Nonprofessional," in *New Careers for the Poor,* Arthur Pearl and Frank Riessman, Free Press: 1965.

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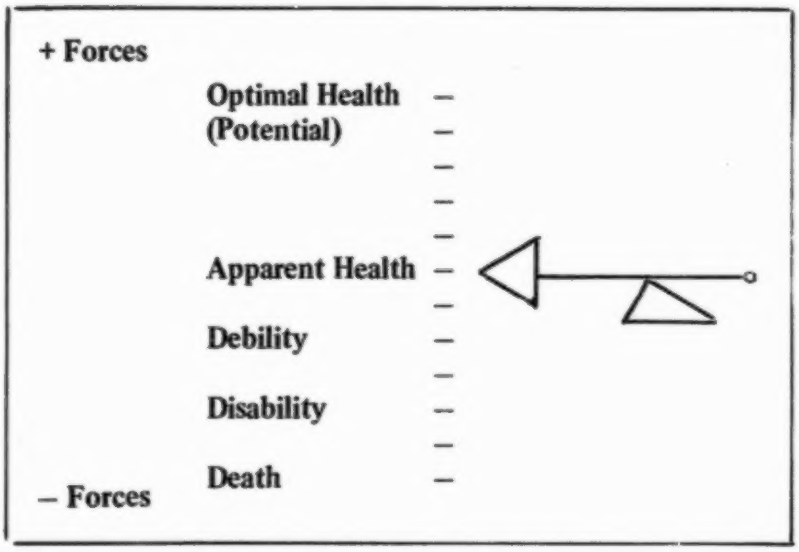
B. BIOLOGICAL POTENTIAL AND EQUILIBRIUM

Overall Objective:

To gain an understanding of the negative and positive forces that affect the biological potential and biological equilibrium of each individual, and to introduce the concept that each person can affect his own equilibrium negatively and positively.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To develop the concept that each of us has a built-in potential at conception.	1. *At conception, each of us has a built-in biological potential.* A. 46 (23 pairs) chromosomes contain genes. B. Genes control optimum height, weight, hair and skin color, eye color, fingerprint pattern, etc. C. Potential can be affected prenatally. 1. Disease – syphilis, rubella (German measles). 2. Radiation – first trimester of pregnancy. 3. Drugs – addiction transferred to child; teratological effect of drugs. 4. Malnutrition – prematurity, developmental. 5. Genetic – phocomelia, Rh factor, "blue baby," sickle cell anemia, PKU.	1. Make a drawing of sperm and ovum on the board. Indicate that many items covered briefly will be discussed in detail in later units. Give examples of prenatal factors.
2. To develop the concept that each of us has a biological equilibrium affected by internal and external forces of a positive and negative nature.	2. *Biological equilibrium is the balance of forces moving us toward or away from our biological potential.* A. The biological equilibrium is portrayed by the following scale: **Diagram 1.**  + Forces Optimal Health (Potential) Apparent Health Debility Disability Death – Forces	2. Place Diagram 1 on board or reproduce and distribute to class; discuss the scale and each part of it. Ask for personal examples of each part of the scale.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
	B. Optimum Health – the highest potential health level for each person. C. Apparent Health – state of health where person "feels okay" but may have some early, undetected health problem. D. Debility – minor illness such as cold, sprain, headache, etc. E. Disability – more serious illness which may require staying in bed or hospital treatment or long-term convalescence, i.e., heart disease, arthritis, cancer, broken leg, etc.	
3. To understand that there are many negative forces which tend to move the biological equilibrium in the direction of debility, disability and death.	3. *Negative forces which tend to move biological equilibrium toward debility, disability and death:* A. Chronic and degenerative disease. B. Communicable disease. C. Poor nutrition. D. Trauma – physical, chemical. E. Mental illness – functional, organic. F. Public ignorance and apathy. G. Inefficient organization and delivery of health services. H. Congenital disease.	3. Scan newspapers for articles illustrating negative forces and relate to health problems of areas to be served by aides. Place them on bulletin board. Cite personal examples.
4. To understand that there are many positive forces which tend to move the biological equilibrium in the direction of optimum health.	4. *Positive forces which tend to move the biological equilibrium in the direction of optimum health:* A. Good personal health habits. B. Immunizations. C. Environmental health controls. D. Sound nutritional practices. E. Health education. F. Periodic checkups. G. Ego preservation and enhancement. H. Health services – law, organizations, personnel.	4. Scan newspapers and magazines for articles illustrating positive forces and relate to resolution of negative forces in areas to be served by aides. Clip and retain articles in scrapbook. Cite personal examples. Prepare list of community health problems that affect potential and equilibrium positively and negatively.

C. PROFESSIONALS IN THE HEALTH FIELDS

Overall Objective:

To gain knowledge of the various types of professions in the health fields.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To gain an understanding of the role of various professionals in the health fields.	1. *Types of professionals.* a. Physician – one who practices medicine, the healing art. (1) Physiatrist – specializes in physical medicine. (2) Internist – specializes in internal medicine. (3) Ophthalmologist – specializes in disease of the eye. (4) Pediatrician – specializes in diseases of children. (5) Obstetrician – specializes in maternity care. (6) Gynecologist – specializes in diseases of the female organs. (7) Proctologist – specializes in diseases of the anus and rectum. (8) Gerontologist – specializes in conditions of the aging. (9) ENT physician – specializes in diseases of the ear, nose, and throat. (10) Surgeon – specializes in surgical treatment of diseases. (11) Psychiatrist – specializes in mental illness. (12) Anesthesiologist – specializes in the administration of anesthesia.	1. General discussion. The trainer should elicit the roles of the specialist from the trainees. As much as possible the trainee will be encouraged to cite examples known to him. Field trip to general hospital to observe aides and professionals performing on the job. Plan with agency for questions and answers on trip.
	b. Nonphysician medical professionals. (1) Health educator – designs educational programs to increase public awareness of the need for improving personal and community health practices. (2) Podiatrist, Chiropodist – treats minor ailments of the feet. (3) Optometrist –Examines the eye for defects and faults of vision and prescribes correctional lenses or exercises.	Invite public health nurse and hospital nurse to discuss the various types of nurses and their specific roles in detail.

(4) Dentist – deals with the prevention and treatment of diseases of the teeth.

(5) Physical therapist – manipulates the muscles, joints, and bones in the treatment of certain symptoms of disease.

(6) Medical social worker – deals with social problems related to health.

(7) Nurse–cares for sick and well persons in giving nursing care under the direction of a physician. There are several kinds of nurses:

  (a) Community – employed by a subdivision of the government to assist in the medical care and supervise the health in a definite locality.

  (b) General duty – assigned to a ward or division of a hospital to perform many different duties for all the patients.

  (c) Graduate – a graduate from a recognized school of nursing.

  (d) Hospital – works for a hospital rather than for one special patient or physician.

  (e) Practical – skilled in the care of the sick but not a graduate from a regular nursing school.

  (f) Private – works exclusively for one patient at a time and is employed by him whether in a hospital or a home.

  (g) Public health – a graduate nurse working for a public health official or a public health agency to assist in safeguarding the health of the people in her district. Gives instruction and actual care to people in their homes and helps in the prevention of disease.

  (h) Registered – a graduate nurse who has passed the state board examination and is thus qualified to be a nurse, and is legally entitled to add R.N. to the name.

  (i) School – a graduate nurse who visits the children in one or more schools, assisting the school physician in his duties.

  (j) Scrub – part of an operating team, being scrubbed, gowned, and surgically clean to assist the operating surgeon.

OBJECTIVES	CONTENT	ACTIVITIES
2. To gain an understanding of the relationship of the Health Service Aide to the professional.	2. *Relationship of Health Service Aide to the professional.* a. The professional always retains the overall responsibility for the care of the patient. b. In some instances, there is a supervisor-supervisee relationship between the two; in others, a co-worker relationship. c. Team concept – both are members of the team. d. The Health Service Aide provides support to the professional member of the team. e. In some specific instances, the Health Service Aide may be directed to work independently of the professional. f. The Health Service Aide must consult the professional when in doubt as to the proper course of action.	2. Group discussion should include examples of how each type of relationship operates in the working situation. Invite director of health agency in which the aides are to be trained and/or employed to discuss team concept. He will cite examples in agency program.

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Suggested Films and Filmstrips on Professionals in the Health Fields

All materials can be obtained from the United States Government, Washington, D.C., Government Printing Office.

1. *The Nurse Combats Disease.* (filmstrip) U.S. Public Health Service, 1961.

2. *Recreational and Occupational Therapy.* (filmstrip) U.S. Office of Education with the cooperation of U.S. Public Health Service, 1945. Made by Ted Nemeth Studios.

3. *The Doctor.* (motion picture) U.S. Office of Inter-American Affairs, 1946. Made by Julien Bryon. Released for educational use in the United States through U.S. Office of Education, 1949.

D. PUBLIC HEALTH ADMINISTRATION

Overall Objective:

To develop an understanding of the concepts of public health administration.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To understand the differences between individual and public health.	1. *Individual health.* a. Individual health is the optimum physical, social, psychological, and mental well-being of a person. b. Health care, treatment, guidance and overall supervision are provided for one patient. c. The health team is concerned with just one person as it provides curative, preventive or rehabilitative care.	
2. To understand the differences between public and individual health.	2. *Public health.* a. Public health is the optimum social, physical, psychological, and mental well-being of all the persons within a prescribed geographic area. b. The primary emphasis in public health is on promotion of health and prevention of disease. c. Primary prevention involves considerations that tend to promote optimum health such as adequate rest, fresh air, adequate diet, and proper exercise. d. Secondary prevention involves those elements of the health program that are specifically geared toward prevention and early detection of diseases such as immunizations and tuberculin testing. e. Tertiary prevention is the prevention of further complications or debilitating conditions of a particular disease including early detection and treatment of disease. f. Improvement of environmental health is an important function of the public health department. g. Original emphasis was on communicable diseases and environmental health factors; more recent trends involve chronic diseases and comprehensive health programs as well. h. Public health is concerned with the health of the total family.	2. Combination of lecture and group discussion. Invite questions and give frequent examples of real-life situations. Invite the Director of Public Health and/or his designee to discuss the concept of public health administration and how it operates in the agency in which the aides will be employed.

OBJECTIVES	CONTENT	ACTIVITIES
3. To become familiar with the four basic types of health agencies according to the source of authority.	3. *Types of health agencies.* a. Official or public. (1) Source of authority from federal, state or local government. (2) Examples: Federal – United States Public Health Service. State —Maryland State Health Department. Local – Cook County Health Department. b. Voluntary or private. (1) Source of authority from board of directors. May be appointed annually or less frequently. (2) Examples: Home Health Agency. Private hospital. Visiting Nurse Service. Local Cancer Society. c. Parochial. (1) Source of authority is a religious group. (2) Examples: Sisters of Charity Nursing Service. Jewish Home for the Aged. d. Combination agency. (1) The public and private services merge and retain some elements of both groups. The source of authority is a combination of government and private concern. (2) Example: Dayton Combination Home Nursing Service.	3. Have available pamphlets showing examples of each type of agency discussed. As much as possible, use examples from the immediate locale. Advise trainees to retain the pamphlets because the agencies will be discussed in depth at a later date.
4. To gain an understanding of the overall functions and goals of the local public health department (or the official public health agency that provides service to the local community. On an Indian reservation it may be the United States Public Health Service; in a remote county it may be the State Health Department).	4. *Public health department.* a. Functions in the community. (1) An overall responsibility for the public health of the citizens in its jurisdiction. (2) This responsibility is the result of a legal mandate or charge to the agency. b. Organizational structure and specific functioning of the local public health department. (1) Office of the director. (2) Public health advisory board.	4. The trainer will either outline or provide an organizational chart of the agency. The trainees will visit local public health department. Ask heads of various divisions to speak to the group regarding the specific functions. Collect various materials decribing functions and accomplishments of divisions while touring the various facilities.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
	(3) Major divisions. (4) Major subdivisions. (5) Minor subdivisions. (6) Emphasize community organization and nursing service. c. Source of authority and financing. (1) Brief explanation of source of authority. (2) Brief explanation of budgetary process. d. Relationship to other public agencies in the local community; cooperative efforts. (1) Public welfare – categorical programs. (2) School system – school health program. (3) Police – health care of jail inmates; health-screening programs. (4) Recreation – health examinations for various programs. (5) Sanitary engineering – environmental health program. e. Relationship to private agencies in community. (1) Voluntary agencies. May give assistance in: (a) Finance. (b) Staff. (c) Research. (d) Demonstration projects. (e) Direct service. (2) Home health agency in community. (a) Cooperative efforts. (b) Serves similar function. (c) Distinction between persons served by public health department and those served by home health agency.	The trainer will relate classroom work to actual facility being visited during field trips. Each health aide trainee can be assigned a subdivision of the public health department and present an overall view to the other trainees and, in addition, develop a resource card describing the functions, facilities and methods of obtaining care.
5. To gain knowledge regarding the local home health agency.	5. *Voluntary or private agencies: home health agency.* a. Assume the responsibility for bedside nursing service to a selected group of patients in the local community.	5. Visit local home health agency. Have program explained by staff, collect pertinent materials while on field trip.

OBJECTIVES	CONTENT	ACTIVITIES
	(1) The types of services rendered may include professional nursing, home health aide services, physical therapy, nutrition instruction, social service consultation, and occupational therapy.	
	(2) The patient's private physician orders the type of care needed.	
	b. Organizational structure of local voluntary agency.	
	(1) Executive director.	
	(2) Medical advisory board.	
	(3) Board of directors.	
	(4) Functional units.	
	c. Source of authority and financing.	
	(1) Board of Directors makes the broad policy decisions.	
	(2) Contributions.	
	(3) Payment for services.	
	(4) Community campaign fund.	
	(5) Endowments, investments.	
	(6) Reimbursement payments from other private agencies and official agencies.	
	d. Relationship to other private agencies in local community cooperative efforts.	5d. Describe cooperative efforts with other agencies.
	(1) Local Tuberculosis Association.	
	(2) Local Cancer Society.	
	(3) United Foundation.	
	(4) Others.	
	e. Relationship to public agencies in community.	
	(1) Public welfare (possible source of reimbursement payments).	
	(2) Public health department.	
	(a) Distinction of cases (Example: private physician cases–medically indigent).	
	(b) Cooperative efforts.	

OBJECTIVES	*CONTENT*	*ACTIVITIES*
6. To understand the relationship of community health needs to programs.	6. *Health needs and health programs.* a. Public health program. (1) Legal responsibility to give service during communicable disease epidemics. (2) Care and isolation of persons with some communicable diseases (tuberculosis). (3) Various programs initiated to combat major health problems in local community. b. Voluntary health program. (1) Relatively fixed according to purpose as delineated by board of directors. (2) May or may not address itself to a health problem in the local community.	6. Trainer will show examples of the increasing or decreasing functions of the public health department as an attempt to meet changing health needs in the immediate community. Relate morbidity and mortality rates to the various programs of the public health department. Utilize other pertinent data or materials to indicate how the health needs in the community influence the public program.
7. To gain knowledge regarding the staffing patterns of a comprehensive public health department and a home health agency as it relates to types, roles, and hierarchy structure.	7. *Staffing patterns of public health department and home health agency.* a. Type and role of personnel. (1) Public health department. (a) Health officer. (b) Division heads. (c) Major subdivision heads. (d) Minor subdivision heads. (e) Staff public health nurses. (f) Staff nutritionist. (g) Staff social worker. (h) Other staff professionals. (i) Staff nonprofessionals – stressing health aides if applicable. (2) Home health agency. (a) Executive director. (b) Heads of functional units. (c) Staff physical therapist. (d) Staff public health nurse. (e) Staff social worker. (f) Staff occupational therapist.	7. The trainer can assign to individual health aides the task of identifying various types of staff who work in the public health department and the home health agency. The aides will share this information with others in the class. The trainer will discuss the roles of the professionals and nonprofessionals. The trainer will emphasize the importance of the health aide in the accomplishment of agency goals.

OBJECTIVES	CONTENT	ACTIVITIES
	(g) Health aides. b. The health aide and other staff personnel have the contact with the recipient of service–the family and the patient. It is through the staff that the programs are implemented. The health aide and other staff form the very foundation of the public health department and the home health agency.	
8. To gain an understanding of the political body in the local community.	8. *Political functions in the community.* a. The local governmental structure and functions. (1) Legislative. (2) Judicial. (3) Executive. b. Relationship of the political body to the public health program. (1) City ordinances–trash collection, refuse disposal. (2) Other health laws and regulations. (3) Budgetary process. (4) Administrative control. c. Relationship of the political body to the voluntary health program – home health agency. (1) Communicable disease regulations. (2) Health code. d. Relationship of local community government to other political jurisdictions in the area of health. (1) Environmental health problems respect no boundaries – air pollution, water pollution. (2) Regional planning for area-wide health problems. (3) Regional, state, and federal health problems. (4) Examples of each in local community.	8. Visit legislative body preferably when laws are being considered that concern health matters. Visit public hearings on proposed health legislation. Follow health department budget developments in local newspapers. Clip and retain in scrapbook. The trainer will show the organization of the political body in the local community. Member of legislative body will visit to review budget process and explain the legislative process as it relates to the health code and other laws.
9. To acquire some familiarity with various levels of health programs.	9. *Various levels of health programs.* a. Local. (1) Local public health department. (2) Local Tuberculosis Association.	9. Have available pamphlets showing programs on various levels. Invite questions from trainees. Show films.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
	(3) Planned Parenthood Association. (4) Others. b. State. (1) State health department. (2) State branch of Cancer Society. (3) Others. c. National. (1) Federal drug addiction program. (2) National Multiple Sclerosis Association. (3) Others. d. International. (1) World Health Organization (Home base – Geneva, Switzerland). (2) Population Council (Home base – New York City). (3) Others. e. Since organization of health programs is not confined to any one level of functioning, there is interrelationship on all levels. This comes about through direct service, consultation, interagency planning and programming, exchange of personnel, and training programs.	Group discussion. Trainer to encourage responses and specific examples from trainees.
10. To gain an understanding of the concepts decentralization and centralization of health services.	10. *Organization of health services.* a. Decentralization: the organization of a health service with two or more facilities providing the same service. (1) Advantage: brings the service closer to the consumer. (2) Disadvantage: demands greater coordination of service. b. Centralization: the organization of a health service with one location providing the service. (1) Advantage: administration and supervision in one location. Space costs generally less expensive. (2) Disadvantage: Places hardships on persons who do not live in the immediate neighborhood.	10. Group discussion. Trainer to encourage responses and specific examples from trainees.

References on Public Health Administration

All materials can be obtained from the United States Government, Washington, D. C. Government Printing Office.

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2. *Guide to a Community Health Study,* New York, 1961. American Public Health Association.
3. "Organization and Staffing for Local Health Service," Washington, 1961, *Public Health Services Publ.* No. 682.
4. "Distribution of Health Services in the Structure of State Government," Washington, 1952, *Public Health Service Publ.* No. 184, Part 1.
5. "The State Health Department Services and Responsibilities," an official statement of the American Public Health Association, *Am. J. Publ. Health* 44:235, February 1954.
6. Hanlon, John L., *Principles of Public Health Administration.* 4th ed., St. Louis: C.V. Mosby Company, 1964.
7. Mustard, Harry S. and Stebbins, Ernest L., *An Introduction to Public Health.* New York: Macmillan Co. 1959.
8. Katz, Alfred and Felton, Jean. *Health and the Community.* New York: The Free Press, 1965.

Films and Filmstrips on Public Health Administration

1. *Service With Distinction.* (motion picture) U.S. Public Health Service, 1959. (Film on the U.S. Public Health Service.)
2. *The Ancient Curse.* (motion picture) U.S. Dept. of State, 1952. Made by Educational Film Company of America. Released for educational purposes in the United States through U.S. Office of Education, 1952. Film on World Health Organization.
3. *Anyone for Nursing?* (motion picture) U.S. Public Health Service, 1957.

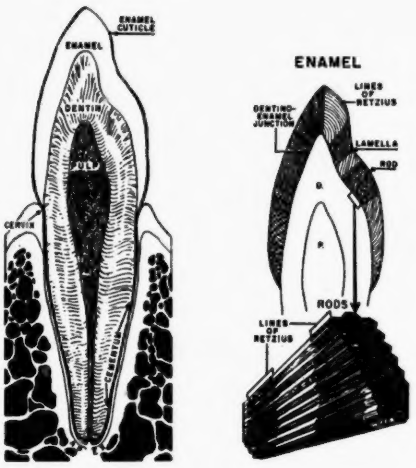
E. THE HUMAN BODY

Overall Objective:

To gain an understanding of how specific parts of the human body function in health and, to a limited extent, in illness.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
	THE DIGESTIVE SYSTEM	
1. To gain an understanding of the digestion of food.	1. *Structure of Digestive Tract* a. The mouth. Digestion of food begins. (1) The mouth is lined with a soft covering which is kept wet by saliva (spit). (2) The roof of the mouth is called the palate. (3) The hard palate is in the front of the mouth and contains bones. (4) The soft palate is in the back of the mouth. (5) The tongue has many papillae; it is through them that we taste our food. (6) Our ability to taste sweet, sour, bitter, and salt is due to the nerves in the papillae. (7) Glands in the oral cavity produce saliva which assists in digestion of food. (8) Grown-ups have thirty-two teeth, sixteen on each side, categorized according to shape. (9) Structure of tooth. (a) The tooth has three essential parts: the crown, the neck, and the root. In the center of the tooth is the pulp which contains nerves and blood vessels.	1. The trainer will utilize charts or drawings that show the different parts of the body that he is discussing. Common names for parts of the body are to be used as often as possible. Allow for frequent questions, answers, and other discussion. Make analogies to mechanical functions of machines when possible and other nonhuman objects.
	(b) The pulp is surrounded by a bone-like layer called dentine. (c) The crown is covered by enamel that is harder than the dentine.	At this point, the trainer may wish to discuss oral hygiene with the trainees.

Parts of a Tooth:


ENAMEL CUTICLE
ENAMEL
DENTIN
PULP
CERVIX
CEMENTUM
ENAMEL
LINES OF RETZIUS
DENTINO-ENAMEL JUNCTION
LAMELLA
ROD
D
P
RODS
LINES OF RETZIUS

b. The alimentary canal. Food is swallowed and enters the alimentary canal (digestive tube), a tube made of muscle that is about thirty (30) feet long.

  (1) The esophagus.

    (a) Section of digestive tube connecting mouth to stomach.

    (b) Digestive action begins immediately once the food is swallowed. The two sets of muscles force the food or water into the stomach.

  (2) The stomach.

    (a) Largest section of the alimentary canal. Pear-shaped, with a three-pint capacity.

    (b) The pyloric valve at the larger and lower end of the stomach retains the food in the stomach until certain digestive changes have taken place.

    (c) At the point where the esophagus joins the stomach there is a cardiac valve which prevents the food from passing again into the esophagus. When vomiting occurs, this valve becomes relaxed.

  (3) The intestine.

    (a) The small intestine is about an inch in diameter and about twenty feet long.

    (b) The large intestine is about five feet long and four inches in diameter.

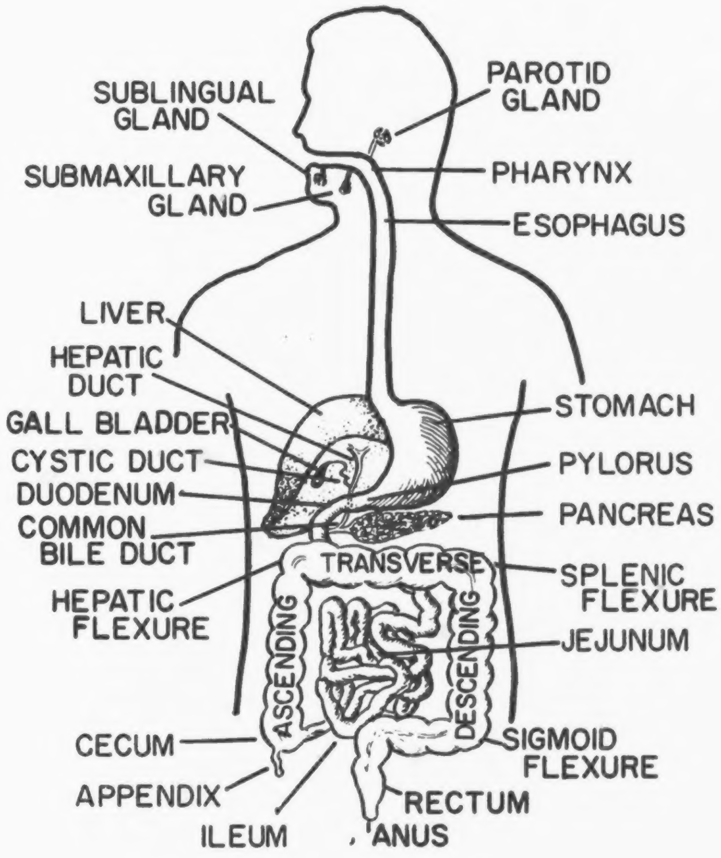
    (c) A short sac called the vermiform appendix is located between the large and small intestines.

(d) Appendicitis affects the vermiform appendix.

(e) The large intestine ends in the rectum.

(f) The opening of the rectum to the outside is the anus.

The Digestive Tract


SUBLINGUAL GLAND
PAROTID GLAND
SUBMAXILLARY GLAND
PHARYNX
ESOPHAGUS
LIVER
HEPATIC DUCT
GALL BLADDER
STOMACH
CYSTIC DUCT
PYLORUS
DUODENUM
COMMON BILE DUCT
PANCREAS
TRANSVERSE
SPLENIC FLEXURE
HEPATIC FLEXURE
ASCENDING
DESCENDING
JEJUNUM
CECUM
SIGMOID FLEXURE
APPENDIX
RECTUM
ILEUM
ANUS

(4) Chemical-producing digestive glands break down food into very small pieces.

(a) The gastric glands produce digestive fluids and are found in the lining of the stomach.

(b) The pancreas secretes pancreatic fluid.

(c) The liver, the largest gland in the body, secretes bile that is gathered in the gallbladder.

(d) There are numerous intestinal glands in the small intestine which secrete intestinal fluid.

2. *Process of Digestion*

   a. Digestion is mechanical, by the teeth and jaws, and chemical, by the action of the chemicals on the food.

   b. Digestion begins in the mouth where the food is broken up by the teeth and mixed with the saliva. The chewing of food well is vital to good digestion.

   c. During this phase, the carbohydrates are changed into soluble sugars.

   d. Before the food enters into the stomach the fluids of the mouth are usually alkaline.

   e. The sugar and starch will not experience further digestive changes until they reach the intestine.

   f. Unless one is physically fatigued or emotionally upset, the food normally remains in the stomach from one to five hours.

   g. Some food may pass into the duodenum, the entrance of the small intestine, within two minutes after entering the stomach.

   h. When food leaves the stomach, it is alkaline. Further biochemical changes occur in the intestine in order to prepare the food for absorption into the body and to separate it from waste materials.

3. *Process of Absorption*

   a. Digested food must be absorbed before it passes into the body and becomes part of the body.

   b. When digested foods are taken into the blood this is known as absorption.

   c. No food is absorbed in the mouth or esophagus; little is absorbed in the stomach.

   d. The small intestine absorbs most of the food intake, although some is absorbed by tiny folds in the lining of the large intestine.

   e. Water is absorbed mainly from the large intestine.

   f. Food is absorbed into the blood vessels. This process is assisted by the action of the living cells and the movements of the intestine.

   g. Indigestible foods pass through the small intestine into the large intestine and then through the rectum.

   h. It is important that all waste materials are removed from the body through elimination to prevent decay in the digestive tract and also to prevent the passage of poisonous substances into the blood.

OBJECTIVES	CONTENT	ACTIVITIES
	i. Food usually remains in the stomach from one to five hours, in the small intestine, about four hours. It may take from six to 24 hours before it passes through the large intestine.	
	THE CIRCULATORY SYSTEM	
1. To gain an understanding of how blood carries nutrients (the products of digestion) and oxygen through various parts of our body.	1. *Blood – Its Composition and Function* a. Blood carries oxygen and nourishment to the cells of the body and carries waste materials from them. b. Blood is made up of red corpuscles, white corpuscles, platelets, and plasma. The composition of the blood changes as it passes through the various parts of the body. (1) Red corpuscles contain a substance called hemoglobin. (2) Red corpuscles carry oxygen from the lungs to the cells in the body. (3) The oxygen in the air we breathe unites chemically with the hemoglobin in the red blood corpuscles until it reaches the cells. (4) Oxygen is received from the blood by the body cells, and the blood also carries carbon dioxide away from the cells. (5) Although the red blood corpuscles outnumber the white corpuscles, the white corpuscles are larger. They are able to change shape. They have the ability to surround and digest bacteria. (6) Blood platelets are small, ameboid bodies which help in the clotting of blood. (7) The blood plasma is straw-colored and varies in composition from time to time. It contains the foods heading toward the cells and also the waste products going to the kidneys, lungs, and skin.	1. Show charts depicting blood circulation. Allow for frequent questions and answers. Encourage group discussions. Common names of the parts of the body are to be used as often as possible.
	(8) Normal body temperature of an adult is about 98.6°F. This is called the blood heat, because the temperature is evenly distributed throughout the body.	Take oral temperatures. Average results. Take pulse and respiration rates. Average results.
	2. *Systematic Circulation* a. As blood passes through the lungs, it secures a fresh supply of oxygen. From the lungs, the blood passes to the left side of the heart.	

b. The heart continuously pumps the blood to all cells in the body. It is located in the left side of the chest cavity between the lungs.

   (1) The pumping action of the heart generates a rhythmic wave called the pulse. By measuring the pulse, the rate of heart beats is determined.

c. After blood is pumped from the left side of the heart, it passes through the arteries, capillaries, and veins, then returns to the right side of the heart.

   (1) The arteries carry blood away from the heart.

   (2) The largest of the arteries is the aorta.

   (3) The aorta spreads out into smaller arteries which penetrate every organ in the body.

   (4) Once these arteries enter the various organs, they divide into capillaries which carry the blood into close contact with all cells in the body to supply them with oxygen and foods (in solution) and to absorb carbon dioxide from them.

   (5) The capillaries return deoxygenated blood to the smaller veins.

   (6) The smaller veins eventually unite into two main veins which will carry the blood back to the right side of the heart.

d. The right side of the heart pumps the blood into the lungs where it loses the carbon dioxide picked up from the cells and secures a fresh supply of oxygen. During this process, the blood changes from a bluish red to a bright red.

3. *Portal Circulation*

   a. This process carries blood from the digestive organs to the liver.

   b. Once it passes through the liver, the blood is carried back to the heart.

   c. Digested foods are collected from the digestive organs and carbohydrates are left in the liver, where they are stored as glycogen.

THE RESPIRATORY SYSTEM

1. To gain an understanding of how the human body breathes.

1. The purpose of breathing (respiration) is to receive air containing oxygen into the lungs and to rid the lungs of air containing carbon dioxide.

   a. When air is taken into the lungs, it is called inspiration.

1. Show charts of the human lung. Ask questions during session to determine what parts are unclear and need further explanation.

   b. When air is forced out of the lungs, it is called expiration.

2. When inspiration takes place, the cartilages to the ribs are bent, the abdominal walls are stretched, and the muscular diaphragm is pushed down.

3. The contraction of the muscles during this process increases the volume of the chest cavity causing an inrush of air.

4. The air goes into the nose and then into the windpipe, or trachea.

   a. The opening of the trachea is covered by the epiglottis which is raised during breathing and closed when swallowing foods.

5. The trachea leads into the larynx which is below the opening of the windpipe. The larynx has several large pieces of cartilage lined with a membrane.

   a. Inside the membrane of the cartilage are elastic tissues called vocal cords.

6. The windpipe has two branches entering into each lung. The branches are called bronchi. Air is carried to the lungs through the windpipe and bronchi.

7. The lungs are elastic and feel like sponge.

8. Each bronchus branches out many times, penetrating the entire lung.

9. Each of these branches ends in a sac called an air sac.

10. The walls of the air sacs are very thin and are surrounded by capillaries.

11. These walls catch the waste materials from the air we breathe, allowing the oxygen to pass through.

12. The oxygen is then absorbed into the blood passing through the capillaries.

13. At the same time, carbon dioxide is expelled from the blood and passes back through the walls of the air sacs.

14. When the respiratory muscles relax, the rib cartilages stretch to increase the abdominal pressure, and the air containing the carbon dioxide is forced out of the lungs.

15. Suffocation results when there is insufficient oxygen being absorbed into the blood.

16. Victims of suffocation can be revived by means of artificial respiration.

THE EXCRETORY SYSTEM

OBJECTIVES	CONTENT	ACTIVITIES
1. To gain an understanding of the process of elimination through various systems of the body.	1. *Organs which excrete waste from the body.* a. Kidneys. (1) Structure. (a) The kidney system is composed of two kidneys, two meters, the bladder, and the urethra. (b) Kidneys are dark-red, bean-shaped and located at the back of the abdominal cavity. Each kidney is about four inches long, two and a half inches wide, and an inch thick. (c) The protective covering of the kidney is called the cortex. The inner portion is the medulla. (2) Function. (a) The kidney extracts waste materials from the blood and delivers them to the bladder in the form of urine. (b) A mass of capillaries called the glomerulus extracts these waste materials. (c) The tubules collect and transport the wastes to the pelvic area. (d) The meters then carry the waste materials to the bladder. (e) The wastes then pass out of the body through the urethra as urine. b. Lungs. (1) Carbon dioxide is removed from the blood in the air sacs and is expelled through the lungs. (2) All exhaled air also contains water vapor.	1. General discussion. Show charts of the different parts of the body. Ask questions frequently to ensure that the trainees understand the material being taught.
	c. Sweat glands of the skin. (1) Sweat glands remove waste and mineral salts from the blood. (2) These excretions appear on the skin in the form of perspiration. (3) Sweat glands are particularly active when the body is overheated. The evaporation of the moisture in perspiration has a cooling effect on the skin.	c. The trainer may wish to point out the necessity of bathing as a means of removing these wastes from the skin.

d. The large intestine. (Refer to discussion of the intestine in the section on Digestive Tract, no. three.)

2. *Importance of water in the functioning of the excretory system.*

   a. Water dissolves waste materials.

   b. A large percentage of the waste excreted through the pores, urinary tract, digestive tract, and respiratory system is water.

   c. Without sufficient water, the excretory functions of the body are severely hampered.

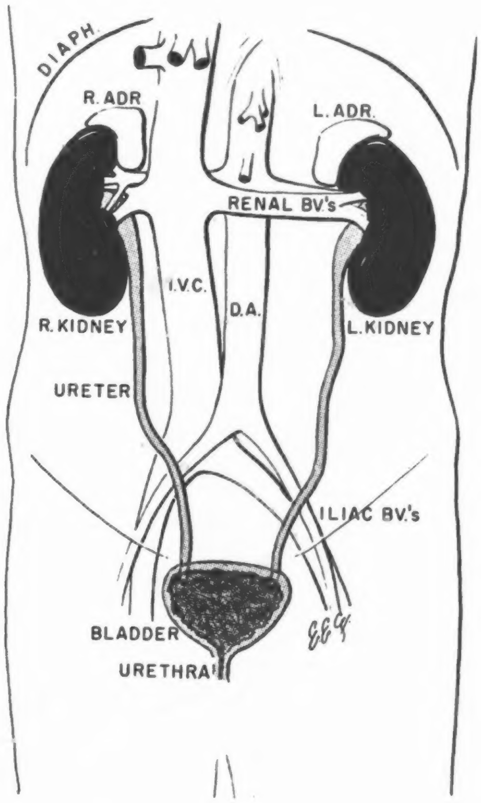
3. *Necessity of excretion.*

   a. If organs function improperly, waste materials remain in the body.

   b. These wastes are poisonous, and good health is dependent upon their excretion.

3. At this point, trainer may wish to emphasize the importance of proper diet as it relates to the excretory system.

The Human Urinary System



THE NERVOUS SYSTEM

1. To gain an understanding of the system that controls all functions of the body.

1. *The Brain*

   a. Organ with overall control of the body.

   b. Consists of three main parts: the cerebrum, the cerebellum, and the medulla oblongata.

1. Show diagrams of nervous system, either by charts or drawings.

   Ask frequent questions of students.

c. The cerebrum.

   (1) Man's most highly developed organ.

   (2) Controls man's thoughts and actions.

   (3) Interprets and relays the messages it receives.

   (4) Enables man to learn and profit from his experiences to a greater degree than lower animals.

d. The cerebellum.

   (1) Controls balance and voluntary muscles.

   (2) Aids in regulation of muscles used in walking, writing, etc.

e. The medulla oblongata.

   (1) Controls the involuntary muscles and the activities of our internal organs: heartbeat, respiration, etc.

2. *The Spinal Cord*

   a. A long rod of nerve tissues that is protected by the backbone and extends to the end of the back.

   b. It connects the brain with the nerves in each part of the body.

   c. Carries messages back and forth between the brain and the nerves.

      (1) Example: Reflexive action – touching hot objects results in quick withdrawal.

3. *The Nerves*

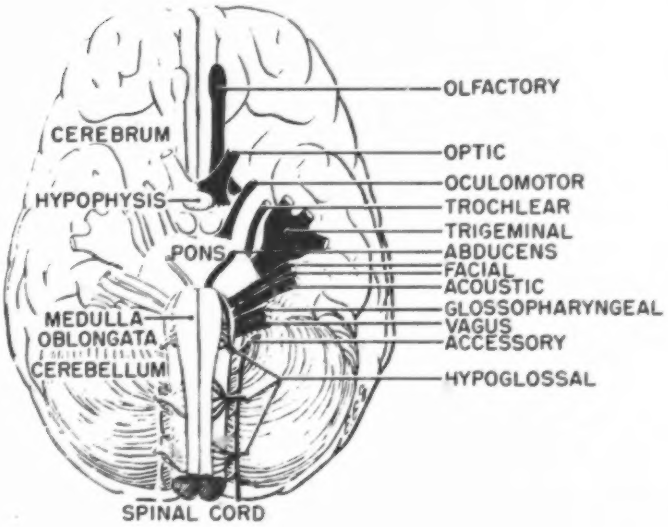
   a. Nerves are composed of and connected to nerve fibers.

   b. Cranial nerves come directly from the brain.

   c. Spinal nerves come directly from the spinal cord.

   d. Nerves connecting the brain and spinal cord are protected with a thick, fatty substance called white matter.

   e. Gray matter is found in all nerves and helps to transmit the impulses (messages).

OBJECTIVES	CONTENT	ACTIVITIES
	Parts of the Nervous System  OLFACTORY CEREBRUM OPTIC OCULOMOTOR HYPOPHYSIS TROCHLEAR TRIGEMINAL PONS ABDUCENS FACIAL ACOUSTIC GLOSSOPHARYNGEAL MEDULLA OBLONGATA VAGUS ACCESSORY CEREBELLUM HYPOGLOSSAL SPINAL CORD	
	THE SENSORY SYSTEM Nose, Tongue, Skin, Eyes, and Ears	
1. To gain an understanding of how the human being perceives, or senses the outside world.	1. *Sense of Smell* a. In smelling, impulses are created and carried directly to the brain where there is stimulation of the olfactory nerve. b. The impulses are interpreted and sent back with orders or warnings. Example: We are warned when we smell smoke and realize that something is burning.	1. Provide charts or drawings of material covered. Question trainees frequently to ensure that they understand the information being taught.
	2. *The Sense of Taste* a. The tongue is the organ of taste. b. There are taste buds called papillae which are found on the tongue. c. Once the impulse reaches this area, one is able to identify substances as sweet, sour, salty, or bitter.	
	3. *The Sense of Touch* a. Nerve endings in the skin are sensitive to a variety of stimuli. Examples: heat, cold, pain, pressure. b. When nerve endings receive stimuli, an impulse is transmitted to the spinal cord. From there, it is sent to the brain for interpretation. The brain then directs the proper reaction to the stimulus.	
	4. *The Sense of Sight* a. Structure of the eye, the organ of vision. (1) In shape, the eye consists of a large sphere, with the segment of a smaller sphere, the cornea, in front.	4. Present the structure and function of the eye, using diagrams and charts.

(2) The eye is composed of three layers of tissue.

   (a) Sclerotic – white and fibrous covering of the eyeball. Becomes transparent and is called the cornea over the colored part of the eye.

   (b) Choroid – layer filled with blood vessels and pigment. This layer forms the iris, or colored portion of the eye. In the center of the iris is the pupil, which gathers the light rays to be focused through the lens immediately behind it.

   (c) The retina - layer which receives the image focused through the lens. It contains nerves which are sensitive to light. This layer also contains the ciliary muscles which operate the lens of the eye.

(3) The eye contains two liquid substances.

   (a) The aqueous humor - located between the iris and the cornea.

   (b) The vitreous humor – a jelly-like fluid located between the lens and the retina.

b. Functioning of the eye.

(1) The eyes receive light rays from everything within the range of vision.

(2) Light rays pass through the transparent cornea, the aqueous humor, and the pupil before reaching the lens.

(3) The light rays are bent as they pass through the lens until they focus on the retina, as an image focuses on a movie screen.

(4) The image on the retina is extremely small.

(5) The sensitive nerves of the retina are affected by the light rays, and descriptive impulses travel along the optic nerve to the cerebellum.

(6) When the impulses register in the cerebellum, we see the image on the retina in its proper size.

c. Common types of eye defects correctable with glasses.

(1) Farsightedness – one can see distant objects clearly, but there is difficulty in seeing objects which are near.

(2) Nearsightedness occurs when the eyeball is too long. Objects are indistinct, because their image is focused in front of the retina, rather than on it.

(3) Astigmatism – defective curvature of the lens or the cornea so that the image is not focused clearly on the retina.

d. Care of the eye.

(1) It is advisable to have sufficient light when reading.

(2) Any blurring of sight or "rainbow rings" around lights requires an examination by an ophthalmologist.

(3) Objects which get in the eye and are not washed out by tears or removed with a sterile cotton swab should be removed by a physician.

5. *Sense of Hearing*

a. Structure of the ear. Three major divisions.

(1) The outer ear – the visible part of the ear which directs the air vibrations inward.

(2) The middle ear–connected with the outer ear by a tube called the eardrum. The middle ear aids in strengthening the vibrations. Located in the middle ear are three bones known as the hammer, the anvil and the stirrup.

(3) The inner ear – contains membranes sensitive to the vibrations.

b. Functioning of the ear.

(1) Sound reaches the ear in the form of air vibrations.

(2) Vibrations pass from the outer ear, enter the ear canal, and beat against the eardrum.

(3) The eardrum begins to vibrate, setting the hammer in motion, and causing it to strike the anvil.

(4) This makes the stirrup beat against the membrane of the inner ear.

(5) The vibrations are picked up by the cochlea, a snail-shaped canal filled with liquid.

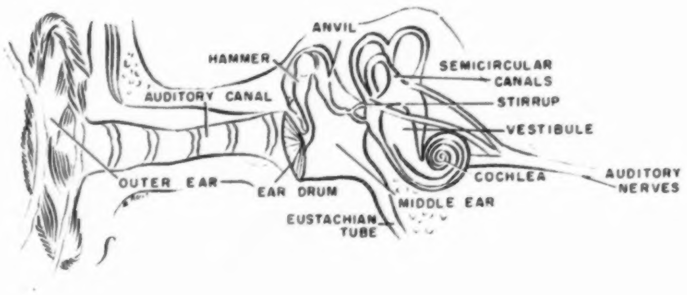
(6) Nerve endings receive the vibrations from the fluid and transmit impulses to the brain, where they are interpreted as sound.

c. Care of the ears.

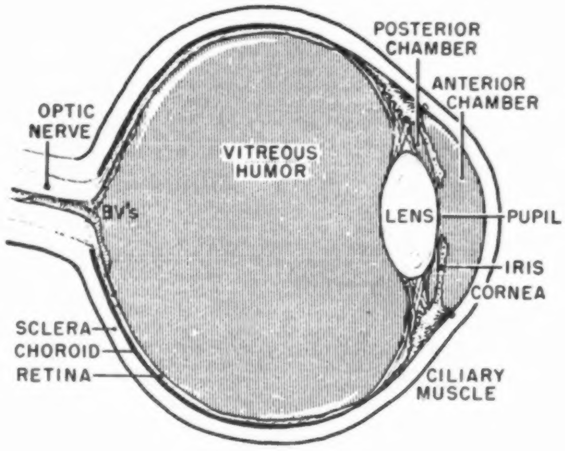
(1) One should never pry or dig into the ears, as it may be very dangerous.

(2) If a person blows his nose improperly this can force mucus into the Eustachian tubes, causing congestion, inflammation, and middle-ear infection.

Parts of the Ear


ANVIL
HAMMER
SEMICIRCULAR CANALS
STIRRUP
AUDITORY CANAL
VESTIBULE
COCHLEA
AUDITORY NERVES
OUTER EAR
EAR DRUM
MIDDLE EAR
EUSTACHIAN TUBE

Parts of the Eye


POSTERIOR CHAMBER
ANTERIOR CHAMBER
OPTIC NERVE
VITREOUS HUMOR
BV's
LENS
PUPIL
IRIS
CORNEA
SCLERA
CHOROID
RETINA
CILIARY MUSCLE

THE ENDOSKELETON
Bones and Cartilage

1. Height and general body structure are determined by the size and strength of bones.

2. Bones serve as the attachment of muscles and protect the body organs.

3. Body regions.

   a. The head, trunk, and limbs make up the regions of the body.

      (1) The trunk is divided into the chest and abdomen.

4. Three important body cavities.
   a. Cranial cavity contains the brain which controls the nervous system.
   b. The thoracic cavity contains the lungs and the heart.
   c. The abdominal cavity contains the stomach, intestines, liver, kidneys, and reproductive organs.

5. *The Bones.*
   a. The skeleton of man includes more than two hundred separate bones.
   b. Bones of the skull and face.
      (1) In the adult skull (cranium), the bones are fused, and they are not easily recognized by themselves.
      (2) The arched structure of the skull gives it great strength, making the brain the best protected organ in the body.
      (3) Eyes are protected by the deep sockets in the front.
      (4) The bones of the face are mostly paired.
      (5) Cheek bones are protected by the bones of the nose.
      (6) The upper and lower jaws constitute the remaining important bones of the skull.
   c. The spinal column consists of thirty-three segments, called vertebrae.
      (1) These vertebrae enable us to turn and bend the trunk in various directions.
      (2) They also support the head and the weight of the body.
      (3) The seven neck vertebrae make it possible to turn the head and to change its position to aid in balancing the body.
      (4) The ribs are attached to the twelve chest vertebrae.
      (5) The five vertebrae in the lower back make it possible to bend at the waist and twist the body in many directions.
      (6) The sacrum in the pelvic region consists of five immovable fused vertebrae.

2

(7) At the base of the spine are four more vertebrae fused to form the coccyx.

d. The ribs.

(1) Twelve pairs of ribs are attached on one end to the vertebrae of the spinal column.

(2) The other ends of the upper seven are attached directly to the breastbone by flexible cartilage which permits freedom of movement necessary in breathing.

(3) Of the other five, the upper three are indirectly attached; the two lower, having no cartilages, are the floating ribs.

e. The arm.

(1) Humerus - long bone which extends from the shoulder to the elbow.

(2) Radius and ulna – two bones in the forearm.

(3) The row of small bones in the wrist is called the carpus.

(4) The finger bones are called the phalanges.

f. The leg.

(1) The upper bone of the leg is called the femur.

(2) Two bones, the tibia and fibula, extend from the knee to the ankle.

(3) The ankle bones are called tarsuses.

(4) The toe bones are called phalanges.

(5) The knee cap is an extra bone and is called the patella.

g. Two bones, the collar bone and the shoulder bone, join the arms at the shoulder.

h. The hip girdle or the pelvis joins a number of the vertebrae to furnish support for the body and permit flexibility of the legs.

i. Mending broken bones.

(1) When the bones of a limb are broken, the broken ends are brought together, and the limb is placed in a splint or cast until new bone forms and hardens to heal the break.

6. *Cartilage.*

   a. The skeleton of the mature adult develops into hard bone from membrane and a soft, elastic material called cartilage. This process begins before birth, and it is not completed until the twenty-fifth year of life.

   b. Examples of cartilage remaining in the mature skeleton are found in the ear and nose.

   c. Young children have a great deal of cartilage in their wrists and ankles and should not be lifted by the hands or allowed to stand for long periods of time.

7. *Joints.*

   a. Joints are found wherever two bones meet.

   b. Joints are divided into three classes.

      (1) Immovable joints are found in the skull of the adult.

      (2) Movable joints are the ball and socket joint such as the shoulder, hip, elbow, knee or ankle.

      (3) Mixed joints are those of the spinal column.

   c. The bones of movable joints are bound closely together by strong bands of cartilage tissue called ligaments.

      (1) The tearing of these ligaments is called a sprain.

      (2) The stretching of ligaments is a strain.

MUSCLES FOR MOVEMENT

1. There are two kinds of muscles: voluntary and involuntary.

2. Involuntary muscles occur in layers in the walls of the digestive tract and the blood vessels.

3. Voluntary muscles.

   a. Structure.

      (1) Consist of many muscle cells held together by connective tissue.

      (2) A tendon of connective tissue attaches each end of the muscle bundle to the bones.

      (3) Muscles become shorter, thicker, and firmer through use.

b. Action of the voluntary muscles.

   (1) Muscles are used in almost everything we do.

   (2) Voluntary muscles must receive a message from the brain if they are to contract. Each muscle cell contracts as hard as it can when the message is received from the brain.

   (3) A movement performed slowly takes fewer muscle cells than the same movement performed more quickly.

   (4) The greater the number of movements which the body is called upon to perform, the greater the number of muscle cells demanded for the task.

4. Importance of exercise.

   a. During exercise, the heart sends six to nine times more blood through the muscles than during resting intervals.

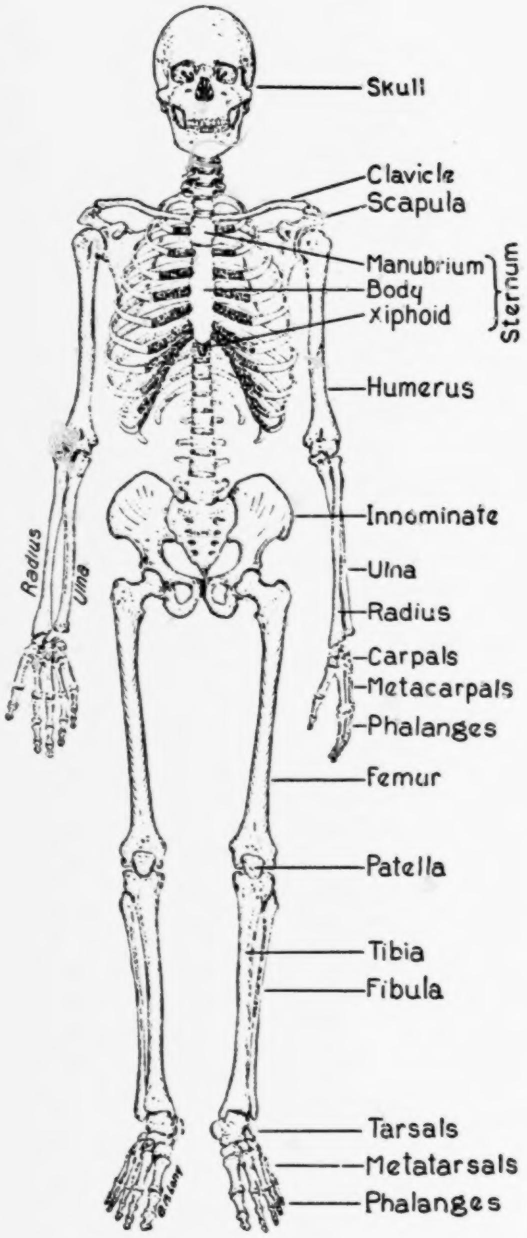
   b. The walls of the large blood vessels in the abdomen contract and those of the skin and working muscles relax so that they get more blood.

   c. The increased blood flow increases the size and strength of the muscles and improves muscular control.

   d. Exercise should be taken regularly and in consistent amounts.

   e. Exercise helps prevent certain blood vessel and heart diseases.

Human Skeleton


Skull
Clavicle
Scapula
Manubrium
Body
Xiphoid
Sternum
Humerus
Innominate
Ulna
Radius
Carpals
Metacarpals
Phalanges
Femur
Patella
Tibia
Fibula
Tarsals
Metatarsals
Phalanges
Radius
Ulna

Filmstrips and Film on the Human Body

All materials listed can be obtained from the United States Government Printing Office, Washington, D.C.

1. *The Body, Part 1.* (Filmstrip) U.S. Dept. of the Navy, 1942. Released through U.S. Office of Education, 1948.
2. *The Body, Part 2.* (Filmstrip) U.S. Dept. of the Navy, 1942. Released through U.S. Office of Education, 1948.
3. *Anatomy and Physiology: The Skeletal System.* (Filmstrip) U.S. Dept. of the Army, 1955.
4. *The Vital Signs and Their Interrelation: Body Temperature, Pulse, Respiration, Blood Pressure.* (Motion picture and filmstrip) U.S. Office of Education with the cooperation of U.S. Public Health Services, 1945.
5. *Anatomy and Physiology: The Muscular System.* (Filmstrip) U.S. Dept. of the Army, 1959.
6. *Anatomy and Physiology: The Digestive System.* (Filmstrip) Dept. of the Army, 1952.

7. *Respiration and Circulation.* (Motion picture) U.S. Dept. of the Air Force, 1960.

Pamphlets:

1. *Anemia.* Rev. 1962 (6) p. 5¢

2. *Circulatory System, Normal and Abnormal Conditions.* Rev. 1963, published 1964. 45¢

F. CONCEPTION

Overall Objective:

To gain an understanding of the processes of life from its beginning to the birth of the newborn.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To understand the concepts of growth and development.	1. *Concepts of growth and development* a. Children are continually growing and developing. b. The primary development of a human being: (1) Follows a pattern, i.e., closure of fontanels, dentition. (2) Uneven in three areas: (a) Soles to pubis (greatest growth) (b) Sternum to head (least growth) (c) Pubis to sternum (moderate growth). (3) Factors influencing growth: (a) Prenatal environment, such as mother's nutrition; position in utero, i.e., club feet; maternal metabolic disease, i.e., diabetes; radiation; infection, i.e., rubella, Rh incompatability; anoxia, or smoking. (b) Heredity (c) Endocrines, i.e. adrenals, pituitary, etc. (d) Illness (e) Nutrition (f) Economic and social, i.e., migratory (g) Emotional, i.e., place in family, etc. (4) Each individual grows at an individual rate, with periods of rapid and slow growth. (5) Any slight deviation from normal growth rate may be the beginning of potential retardation. Need for early recognition and possible plans for habilitation or rehabilitation.	1. Lecture by trainer.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
2. To gain an understanding of male anatomy and physiology.	2. *The male reproductive system* a. Testicles. (1) Produce sperm cells. (2) Contain 500 feet of tubes. (3) Secrete male hormones. (4) Contained within scrotum at birth. (5) Sometimes fail to descend; sterility results if condition not corrected. b. Vas deferens is a passageway for sperm. c. Seminal vesicle – where sperm are stored and come to maturity. d. Prostate gland and cowperis gland – secrete a liquid in which sperm move about. e. The urethra is the passageway through which urine and sperm leave the body through the penis. f. When sperm are being expelled (ejaculation), the bladder is shut off by a ring of muscle called a sphincter muscle. The penis becomes erect prior to ejaculation. g. Semen is the fluid that contains sperm, about 4 to 5 million sperm per teaspoon. Semen travels through the vagina and female reproductive organs to meet ovum.	2. Lecture by trainer. Questions from trainees. Source material: chart of male anatomy and various pamphlets. Films from local health department, university, junior college, or Planned Parenthood Association that show the process of conception and fetal maturation.
3. To gain an understanding of the anatomy and function of the reproductive organs of the female.	3. *The female reproductive system* a. Ovary. (1) When a girl is born, her ovaries contain all of the ovum she will ever have, but they are immature until she reaches adolescence. (2) Produces hormones which affect size of breasts, growth of pubic hair, and hips. (3) Ovulation (ripening of ovum) occurs every 28 days. b. Fallopian tube. (1) Receives ovum which travels to uterus where it may unite with sperm. (2) Sperm determines sex of child. (3) Cells multiply after the ovum and sperm unite.	3. Lecture by trainer. Questions from the trainees. Source material: chart of female anatomy and various pamphlets.

OBJECTIVES	CONTENT	ACTIVITIES
	(4) Ectopic pregnancy sometimes occurs in the tube or abdomen. c. Uterus. (1) Holds the fertilized egg. (2) Nourished by hormones. (3) Fertilized cell attaches itself to wall. (4) E.D.C. (Ending Date of Confinement). Count 3 months back from first day of last menstrual period. Add one year and seven days. Example: July 1, 1965 - April 8, 1966.	
4. To gain an understanding of the growth and development of the embryo and fetus.	4. *Growth and development of child in utero* a. 4–6 weeks (1) Baby floats in amniotic fluid in a sac which protects him from jar or injury. (2) Heart starts to beat. b. 7 weeks (1) Tiny arm and leg buds become visible. (2) Placenta, umbilical cord become visible. (Mother breathes, eats, eliminates for child via placenta.) c. 3½ months: looks like baby. d. At 4–5 months, the mother can feel the baby moving. e. 7 months (1) Can live if born. (2) Can contract syphilis after this stage of development through placenta; can also be treated while in utero. f. 9 months (1) Birth. (2) Can contract gonorrhea as it is born; before, sac protected child.	4. Combination of lecture and group discussion. Charts showing the process under discussion.

OBJECTIVES	CONTENT	ACTIVITIES
5. To understand the meaning, issues, and method relative to contraception.	5. *Contraception* a. Definition – the process of preventing, by various means, the uniting and maturation of a sperm and ovum in the human body. b. Some issues regarding the practice of contraception: (1) Moral, ethical considerations. (2) Religious prohibitions – condemnations by church. (3) Legal considerations – laws prohibiting the supplying of information and methods of birth control. c. Methods of contraception: (1) Withdrawal (coitus interruptus): the withdrawal of the penis from the vagina immediately prior to ejaculation. (a) Widely used in European, African, and Asian countries. (b) Very unreliable. Some semen may be on the penis prior to intercourse, and the withdrawal may be poorly timed. (c) Action – prevent sperm from entering vagina. (2) Rhythm method. (a) Refraining from intercourse during the woman's "fertile period," the days just prior to, during, and just following ovulation. Considering the first day of the menstrual period as day one, ovulation usually (although by no means always) occurs on day fourteen. The use of the rhythm method would require abstention from intercourse from approximately day ten through day eighteen. (b) The effectiveness of this method is difficult to judge. If the individual woman's cycle is predictably regular, and ovulation occurs at the same point during each monthly cycle, then the method may be quite effective. If no pattern can be established, however, the use of the rhythm method may not prove an effective means of contraception. This is the only method of family planning which has the full approval of the Catholic church, and thus is widely practiced.	5. Have member of Planned Parenthood staff or official birth control program or other local family planning service discuss goals and operation of program.

- (c) Action – to prevent the sperm from uniting with the ovum during the period of time when it is susceptible to fertilization.

(3) Condoms (rubbers, prophylactics).

- (a) Thin rubber sheath that covers the penis and prevents the semen from entering the vaginal tract.
- (b) Very reliable, if the sheath is properly placed on the penis, the material used in manufacturing the condom is high quality and contains no defects, and following intercourse the semen is not allowed to escape from the sheath into the vagina.
- (c) Used widely in the United States, France and other European countries among all income levels and age groups.
- (d) Action – prevent sperm from entering vagina.

(4) Vaginal suppositories.

- (a) Cone-shaped gelatinoid suppository with some spermicidal chemical in some brands, others with hygienic chemical compounds only.
- (b) Reliability depends on type used. Those without spermicidal chemicals are totally ineffective. Others are relatively good.
- (c) Used decreasingly in U.S. as a result of education programs regarding their ineffectiveness.
- (d) Action – in some cases immobilize and kill sperm.

(5) Douche.

- (a) Vaginal rinsing using continuously flowing water and usually vinegar or a brand name cleansing agent. Used following intercourse.
- (b) Used widely among educationally disadvantaged persons in the U.S.
- (c) Very ineffective as a contraceptive measure.
- (d) Action – in some instances washes out sperm and makes sperm less effective in the acid medium.

(6) Foam.

(a) Manufactured with a spermicidal agent as part of its composition. Contained in a tube. Plunger used to insert foam in vagina. Placed in vagina immediately prior to intercourse.

(b) Used in some western countries including the U.S.

(c) Reliability approximately 70%. Problems of use: retention of its potency while in the tube; deterioration of chemical compound (due to exposure of tube to heat and length of time compound remains in tube); messy sensation; and long lapse of time between placing foam in vagina and intercouse increase ineffectiveness. Infrequently causes allergic reaction.

(d) Action – immobilize and kill sperm.

(7) Jellies.

(a) Manufactured compound with spermicidal chemical. Consistency of jelly. Inserted with plunger or used with a diaphragm.

(b) Wide acceptance in U.S. and other western countries. Use decreasing due to increasing use of newer methods.

(c) Reliability approximately 75%. Higher reliability when used in conjunction with diaphragm. Problems of use involve messiness and infrequent allergies.

(8) Diaphragm.

(a) Heavy rubber cup-like device that fits over cervix. Applicator may be used to facilitate insertion. It is recommended that approximately 2 tablespoons of jelly be used – one tablespoon around the rim and the second tablespoon in the cup. Place in vagina immediately before intercourse.

(b) Reliability approximately 85% when inserted properly. Problems of use involve improper fitting by physician, length of time diaphragm must remain in place following intercourse, and deterioration of rubber after long period of use.

(c) Use decreasing as a result of newer methods.

(d) Action – prevent sperm from entering cervix. Spermicidal when jelly used.

(9) Intrauterine device.

(a) Lippes loop, coil, button, and other shapes. Devices are inserted in the body of the uterus by a physician. Made of non-allergic polyetheline material. Very inexpensive to manufacture.

(b) Used widely in the U.S., India and some European countries.

(c) Reliability approximately 90%. Problems with use involve expulsion, ruptured uterus, and occasional bleeding and pain.

(d) Action – specific action not known.

(10) Pills.

(a) Synthetic hormones in pill form. Medication cycle: take pill for twenty consecutive days, refrain for five days (during which time menstrual period occurs), then recommence cycle. Some variations among many types on the market.

(b) In most programs in the U.S. that offer all methods of contraception, the pill users far outnumber persons using other methods.

(c) Reliability 99%. Problems with use include: contraindication resulting from allergies, chronic diseases, and untoward effects; forgetting to take pills; and inability to comprehend directions for using pills.

(d) Action – prevent ovulation.

(11) Tubal ligation.

(a) Severance and tying of Fallopian tube in female.

(b) Requires major surgical procedure. Only accessible to those women who can obtain surgery for this purpose. In many areas availability of other contraceptive measures has reduced demand.

(c) Reliability 99.9%. Rare cases where women have conceived following procedure.

(d) Action – sever and occlude tract for passage of ovum.

OBJECTIVES *CONTENT* *ACTIVITIES*

(12) Vasectomy.

- (a) Severance of the vas deferens in males.
- (b) Requires surgical procedure. Problems of use: disadvantages of minor surgical procedure and difficulty in obtaining consent of male.
- (c) Failure rates have been as high as 30% in some programs. Few males submit to procedure.
- (d) Action – severance of the tract for passage of sperm in the male.

(13) Methods still in experimental stage:

- (a) Morning-after pill.
- (b) Monthly and yearly injection.
- (c) Pills for male.

G. GROWTH AND DEVELOPMENT

Overall Objective:

To gain an understanding of the growth and development of a child from infancy through five years of age.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To gain an understanding of the developmental stages of the infant from 29 days to one year.	1. *Physical Development* a. Height: (1) First year – grows 9 inches. (2) Second year – 3-4 inches. b. Weight: (1) By 5 months – doubles birth weight. (2) By 12 months – triples birth weight. (3) By 2 years – weighs 26-28 pounds. c. Fontanels: (1) Posterior closes at 2 months. (2) Anterior closes at 12-18 months. d. Teething: (1) Develops lower central incisors at 5-8 months. (a) May be preceded by salivation at 3-4 months. (b) Accompanied by irritability, anorexia and "mouthing." (2) Usually has six teeth at 12 months – one for every month up to 1 year. e. Tears – at 2 months.	1. Combined lecture and group discussion. Instruction by pediatrician or pediatric nurse consultant. A normal infant can be brought into class, preferably an infant of a friend of one of the trainees. The trainees are to observe the infant and discuss its stage of development.
	2. *Motor Development* a. Basic Principles: (1) Cephalocaudal – head to foot. (2) Proximal to distal – body to extremities. (3) General to specific – gross to finer.	

b. Dependent on:

  (1) Eye-hand coordination.

  (2) Inherent desire.

  (3) Social encouragement (environment).

Note: Spurts, plateaus and regressions are normal in neuromuscular development.

c. Rate of Development:

  (1) One Month:

    (a) Can lift head from time to time when held to shoulder.

    (b) Turns head from side to side in prone position.

    (c) Makes crawling movements and can push with feet against hard surface to move head (passage reflex).

    (d) "Dance" and tonic-neck reflex present.

    (e) Can grasp and immediately release an object.

    (f) Can follow object to midline of vision.

  (2) Two Months:

    (a) Can lift chest short distance above table surface when on abdomen.

    (b) Can turn from side to back.

    (c) Can hold rattle for brief time.

    (d) Tonic-neck reflex disappearing.

    (e) Eyes follow object or moving light.

  (3) Three to Four Months:

    (a) Holds head erect when held to shoulder.

    (b) Looks at hands when they come within range of vision.

    (c) Can turn from back to side.

    (d) "Dance" reflex lost at 3 months, and tonic-neck reflex at 4 months.

2. Schedule visits to Well Baby Clinic, Day Care facilities, pediatric wards in hospital and/or other settings where children are found in numbers. During the visits health aides will observe and record developmental characteristics. Discuss observations as they relate to norms.

(4) Five Months:
   - (a) Sits with slight support.
   - (b) Grasps objects with whole hand.
   - (c) "Moro" reflex lost.

(5) Six Months:
   - (a) Sits momentarily with support.
   - (b) Can completely turn over (accident factor).
   - (c) Bangs rattle or spoon.
   - (d) May bring objects to mouth for investigation (accident factor).

(6) Seven Months:
   - (a) Plays with feet and tries to put them in mouth.
   - (b) Bounces when held in standing position.
   - (c) Approaches, grasps and can transfer a toy from one hand to the other.

(7) Eight Months:
   - (a) Sits alone.
   - (b) Pincers technique (accident factor).

(8) Nine Months:
   - (a) Sits alone.
   - (b) Crawls either by hitching or on all fours (accident factor).

(9) Ten Months:
   - (a) Pulls self to feet.
   - (b) Starts to feed self cracker or cookie.
   - (c) Releases objects.
   - (d) Brings hands together (plays patty-cake).

(10) Eleven-Twelve Months:
   - (a) Stands with support at 11 months.
   - (b) Walks with help at 12 months.
   - (c) Can go from standing to sitting position without help.

OBJECTIVES *CONTENT* *ACTIVITIES*

(d) Can drink from cup, and finger feed.

(e) Can pull off socks, put hand through sleeve.

(f) Can hold crayon and mark on paper.

3. *Language Development*

   a. Dependent on:

      (1) First language uses tone and loudness to denote needs and desires.

      (2) Crying becomes differentiated at 2 months.

      (3) Babbles, coos, squeals at 3-4 months.

      (4) Begins to imitate sounds at 9 months.

      (5) Says 1-2 words and imitates adult's inflection.

      (6) Vocabulary growth is slow (4 words) because baby is involved with learning to walk.

4. *Social Development*

   a. Influencing factors:

      (1) Associated with mother, family or mothering person.

   b. Socialization:

      (1) Basically self-centered.

      (2) "Social smile" in response to another's smile at 2-3 months.

         (a) Smiles in response to mother's face at 3 months.

         (b) Smiles in response to other's smiles at 4 months.

         (c) Initiates social play by smiling at 4 months.

      (3) Pays attention to speaking voice at 2 months.

      (4) Shows increasing interest in other members of family and enjoys people around him at 4 months.

      (5) Begins to recognize strangers at 5-6 months.

      (6) Shows fear of strangers at 7-8 months.

      (7) Plays simple games such as "bye-bye," "peek-a-boo," etc., at 10 months.

      (8) Recognizes the meaning of "no-no."

OBJECTIVES | *CONTENT* | *ACTIVITIES*

(9) Loves rhythms.

5. *Emotional Development*

   a. Dependent on:

      (1) Pleasant and unpleasant experiences and reactions of self with others.

      (2) Cries easily when denied something and thrashes about when frustrated at 6 months.

      (3) Shows emotional instability by easy and quick changes from crying to laughing at 7-8 months.

      (4) Affection or love of family appears at 8 months.

      (5) Cries when scolded at 9 months.

      (6) Shows jealousy, anger, etc., at 12 months.

6. To gain an understanding of the developmental stages of the child from 1 to 2 years.

6. *Physical Development*

   a. Two years:

      (1) Has quadrupled birth weight–26-28 pounds.

      (2) Height is approximately 32-33 inches.

      (3) Has approximately 16 temporary teeth.

      (4) Posture–"Pot belly" with legs apart, slight lordosis and feet slightly pronated for equilibrium (demonstrate).

6. Combined lecture and group discussion. Lecture by pediatrician or pediatric nurse consultant. The trainees are to discuss the development of their own children or brothers and sisters at similar ages.

7. *Motor Development*

   a. Fifteen months (generally has reached a plateau):

      (1) At 14 months walks with wide-based gait to steady self.

      (2) Creeps up stairs.

      (3) Hand coordination.

         (a) Builds tower of two blocks.

         (b) Grasps whole cup and spoon, but may spill contents.

   b. Eighteen months.

      (1) Seldom falls in walking and running.

- (a) At 16-17 months can walk sideways and backward.
- (b) May angulate body forward in running.

(2) Climbs up chairs and onto furniture.

- (a) Can sit self in small chair.

(3) Hand coordination:

- (a) Scribbles, can draw straight line.
- (b) Can throw ball, put peg in hole.
- (c) Build tower of 3 blocks.
- (d) Can drink well from cup, but may still spill from spoon.

(4) Beginning of bowel training.

c. Two years:

- (1) May run away, can jump (with falls).
- (2) Walks up and down stairs, both feet on one step at a time.
- (3) Hand coordination:
    - (a) Imitates vertical lines – more controlled scribbling.
    - (b) Can open doors by turning knob.
    - (c) Can build tower of 5 blocks, and make a train.
    - (d) Can feed self from glass and spoon.
- (4) Indicates when diaper is wet.
- (5) Toilet trained in daytime.
- (6) Helps to undress and dress with assistance.
- (7) Can wash hands with assistance.

8. *Language Development*

a. Dependent on:

- (1) Association and interests.
- (2) Enunciation and understanding of his associates.

(3) Must be talked to at his level simply and directly (demonstrate).

b. Fifteen months:

(1) Uses jargon.

(2) May vocalize and point to a desired object.

(3) Needs familiar objects and pictures (linen picture book). Pats pictures and turns pages.

c. Eighteen months:

(1) Knows 10 words and uses phrases composed of nouns and adjectives.

d. Two years:

(1) Has vocabulary of approximately 300 words.

(2) Makes short sentences of 3-4 words.

9. *Social Development*

a. Eighteen months:

(1) Increasingly aware of strangers.

(2) Solitary play predominant.

(3) Very curious and explorative (accidents).

b. Two years:

(1) Would like to make friends with other children but pushes and pulls them like objects which may end in scrap.

(2) Enjoys parallel play, plays alongside other children rather than with them. Short attention span (5-10 minutes).

(a) Likes push and pull toys, manipulative toys (beads, knobs, peg boards).

(b) May be taught to replace toys in proper place.

(3) Begins to mimic parents' activities (development of humor).

(4) Enjoys storytelling with pictures.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
	(5) Does not know right from wrong. 10. *Emotional Development* a. Eighteen months: (1) Dependency needs may be manifested by: (a) Difficulty in going to sleep. (b) Thumb sucking. (c) Toting favorite toy or blanket. (2) Independence may be manifested by temper tantrums. b. Two years: (1) Shows increasing signs of individuality. (2) Violent temper tantrums and thumb sucking decrease. (3) May fear parents' leaving or change of surroundings (separation anxiety). (4) Develops signs of fear, i.e., rain, wind, dark, trains. (5) Develops humor and love.	
11. To gain an understanding of the developmental stages of the child from 3-5 years of age.	11. *Physical Development* a. Height: grows about 2½ inches each year. b. Weight: gains approximately 4½ lbs. per year. c. Teeth: deciduous. d. Reproductive system practically dormant. 12. *Motor Development* a. Three years: (1) Maintains equilibrium, alternates feet going up stairs and jumps with both feet. (2) Feeds self with few accidents. (3) Needs assistance in dressing self. (a) Cannot differentiate back from front. (b) Has difficulty putting on stockings and shoes, but cannot lace shoes.	11. Combined lecture and group discussion. Lecture by pediatrician or pediatric nurse consultant. A child of four-five years of age is to be brought into the classroom for purposes of observation and determination of development covering the material taught in class.

OBJECTIVES **CONTENT** **ACTIVITIES**

        (c) Able to wash face and hands, and brush teeth with supervision.
    (4) Toilet training:
        (a) Shows awareness, but may wait too long.
        (b) Needs assistance in cleansing genital area.
b. Four years:
    (1) Runs up and down stairs, can stand on one foot.
    (2) Can use tricycle, jungle gym (daring and has accidents).
    (3) Can cut straight with scissors.
    (4) Can dress and undress self, knows front from back and can lace shoes.
    (5) Can usually wash self fairly well, but may get marooned on one part of the body. Needs suggestions and encouragement.
    (6) Usually completely toilet trained, including at night.
c. Five years:
    (1) Is almost self-dependent in washing, toileting, dressing, feeding.

13. *Language Development*
    a. Three years:
        (1) Vocabulary: 700-1000 words.
            (a) Enjoys talking, telling stories.
        (2) Expresses desires and refusals. ("I don't want to" rather than "no.")
        (3) Asks for confirmation of task. ("Is that right?")
    b. Four years:
        (1) A great talker, asking "why" and "how."
        (2) Likes different words and enjoys saying silly words.
    c. Five years:
        (1) Conversation simple and unsophisticated.
        (2) Continues to ask "why."

14. *Social Development*
    a. Three years:
        (1) Becomes more sociable.

(2) Parallel play, but more cooperative and can wait turn.

(3) May have imaginary playmates.

(4) Can put toys away with supervision (beginning of orderliness).

(5) Interested in new experiences (trips, etc.).

b. Four years:

(1) Very sociable, wants to play with others.

(2) May be bossy and need supervision in groups.

c. Five years:

(1) May play alone occasionally.

(2) Interested in school.

(3) Knows difference between social and antisocial behavior. Possesses a sense of justice.

(4) Guidance needed in:

(a) Development of toilet habits.

(b) Learning to walk.

(c) Social norms.

15. *Emotional Development*

a. Basic needs:

(1) Emotional security, love and affection.

(a) Needs to feel as well as see these demonstrated and gain a positive response.

(b) Needs a transitional love object such as toy or blanket.

(c) Harmony within the home as expressed in attitudes and reactions of family members.

(d) Consistency in routines, regulations, environment.

(e) Respect for individuality – someone to look at his work, to do things with him and recognize and accept his ritualism.

(2) To develop independence to promote physical and social security (lack may cause doubt and/or withdrawal).

(a) Needs time for doing things himself (grooming and personal hygiene).

(b) Wants opportunity to choose clothes, toys, and games.

OBJECTIVES	CONTENT	ACTIVITIES
	(c) Needs to explore the world around him. (d) Needs opportunity to begin to understand the value of time, property, money.	
16. To understand growth and development of a child from ages 6 through 12.	16. *The Child Between 6 and 7* a. Has six or seven wrist bones. b. Has one or two permanent teeth. c. Is active in games such as running, jumping, chasing and dodging. d. Can dress himself without help and tie shoe laces. e. Enjoys group play. f. Plays together with boys and girls. g. Has vocabulary of about 2,500 words. h. Knows comparative value of the common coins. i. Knows number combinations up to 10.	16. Lecture by pediatrician or pediatric nurse consultant. The trainees can discuss content in relation to children they know.
	17. *The Child Between 7 and 8* a. Gains from 3 to 5 pounds of weight each year. b. Steadily increases in height. c. Jump rope, hop-scotch and jacks played by girls. d. Can recognize property rights. e. Begins to compete at play. f. Can count by 1's, 2's, 5's and 10's. g. Can tell time, run errands, make purchases, knows what month it is. h. Is curious about sex differences.	
	18. *The Child Between 8 and 9* a. Has ten or eleven permanent teeth. b. Is interested in games requiring muscle coordination. c. Is able to write progressively better. d. Can swim well if taught. e. Can bicycle and roller skate expertly. f. Develops increasing modesty. g. Enjoys and participates in group projects. h. Manners are often better away from home than at home. i. Becomes more selective in choice of friends.	

j. Enjoys fairy tales.

k. Can tell day of month and year.

l. Can make change for small amounts.

m. Begins to read the funnies.

19. *The Child Between 9 and 10*

   a. Grows slowly in height.

   b. Last wrist bone appears in girls.

   c. Is able to care for physical needs without assistance.

   d. Sex differences become apparent in play; boys and girls like different kinds of games, etc.

   e. Antagonism between sexes becomes noticeable and remains for next several years.

   f. Gang and club enthusiasm become noticeable.

   g. Can grasp simple multiplication and division facts.

   h. Reading interests become noticeable.

   i. Shows interest in how things are made or produced.

20. *The Child Between 10 and 11*

   a. Rapid increase in weight may begin in girls.

   b. Has 14 or 16 permanent teeth.

   c. Shows interest in hazardous activities.

   d. Boys become more active and rough in playing games than girls.

   e. Begins to like organized and competitive games.

   f. Shows interest in team work.

   g. Needs occasional privacy.

   h. Develops initial ability to plan ahead.

   i. Places importance on gathering factual information (especially boys).

   j. Uses numbers beyond 100 with understanding.

   k. Begins to use and understand simple fractions.

   l. Steadily develops capacity for thought and reasoning.

21. *The Child Between 11 and 12*
    - a. Last wrist bone appears in boys.
    - b. Girls fall behind boys somewhat in physical strength and endurance.
    - c. Menstruation occurs in a few girls.
    - d. May be strongly individual in liking for different games and play involving motor skills.
    - e. Places increasing importance on membership in clubs and groups.
    - f. Takes part in school, neighborhood, and community affairs.
    - g. Becomes more noticeably shy.
    - h. Begins to be critical of own artistic products.
    - i. Can understand human reproduction.
    - j. Understands need for care in using towels, glasses, and public toilets.
22. *The Child Between 12 and 13*
    - a. Plays games involving whole body activity.
    - b. Capable of carrying out good personal hygiene habits.
    - c. Muscles have grown to represent 40 to 45 percent of body weight.
    - d. Has 24 or 26 permanent teeth.
    - e. May be conscious of awkwardness.
    - f. Chooses activities according to individual preferences.
    - g. Enjoys being spectator at games and sports.
    - h. Begins to broaden social contacts.
    - i. Boys admire other boys who are skilled, bold, and daring.
    - j. Girls begin to become ladylike.
    - k. Can add and subtract decimals.
    - l. Develops increased ability to reason.
    - m. Understands abstract ideas like "justice," "honesty," etc.

n. Shows awareness of moral codes.

o. Develops increasing religious interest.

p. Needs sympathetic understanding from parents as adolescence approaches.

23. *Growth and Development Between 12-20 Years of Age*

a. Timing of growth during and through adolescence different in boys and in girls.

b. Girls develop and mature faster than boys.

c. Between 11 and 13 or 14, girls become taller than boys.

d. By 15, the boys have overtaken them.

e. Boys keep adding to their height after girls' growth is complete.

f. From 12 to 15, girls outweigh boys, but they gain very little after 18.

g. Boys gain weight steadily at about 12, gain faster from then through 16, and continue to make smaller gains up to 20.

h. Part of the increasing weight during adolescence is due to growth of the muscles.

i. Boys almost double their strength between 12 and 16 years.

j. Children who are tall in the years between 6 and 10 may be expected to be tall at maturity.

H. NUTRITION

Overall Objective:

To gain an understanding of the importance of nutrition as related to health and disease.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To provide a working knowledge of the practical aspects of nutrition and its application in the maintenance and improvement of health.	1. *Introduction* a. Definitions of: (1) Food (2) Nutrition (3) Diet (4) Food habits and patterns (5) Food fads. b. Food – what it means to people. (1) The factors affecting food habits: (a) Economics (b) Customs (religious and cultural) (c) Food supply (d) Social. (2) The impact of illness: (a) Loss of appetite (b) Mental problems (c) Educational relationship (d) Economic stress. (3) Food misinformation as a deterrent to good nutrition.	1. Lecture and discussion based on practical experience. Shopping trip to neighborhood shopping market to learn to read labels and compare prices.
	2. *Nutritional needs* a. Recommended dietary allowances: (1) Factors determining nutritional needs: (a) Age	2. Refer to Recommended Dietary Allowances of the National Research Council, trainee's manual, page 57.

- (b) Body build
- (c) Activity
- (d) State of health.

(2) National nutrition programs and their significance.

- (a) National School Lunch Program
- (b) Enrichment Program
- (c) Surplus Foods Program
- (d) Free School Lunch

b. Meeting nutritional needs through foods.

(1) Food needed every day:

- (a) Protein foods, their functions and sources
- (b) Vitamins, their contributions and sources
- (c) Minerals, their contributions and sources
- (d) Energy foods, their contributions and sources.

c. Daily food guides:

- (1) Interpretation and use
- (2) Advantages of such a guide.

d. Periods of greatest nutritional needs:

- (1) Growth and activity
- (2) Reproduction and lactation
- (3) Illness
    - (a) Childhood diseases and their affect on growth pattern
    - (b) Importance of appetite.
- (4) Maintenance.

3. *Meal planning for the family*

a. Family pattern:

- (1) Likes and dislikes

(2) Meals away from home.

b. Food budget:

(1) Meal plans

(2) Market order

(3) Storage facilities.

c. Buying practices.

d. Introducing unfamiliar foods.

e. Conserving nutritive value.

f. Sanitation.

4. *When a "special diet" is ordered*

a. General types:

(1) Soft, bland diet

(2) Diabetic diet

(3) Restricted calorie diet

(4) Low fat diet

(5) Low sodium diet.

b. What is the responsibility of the health aide with respect to nutrition problems?

(1) Resources

(2) Materials and their use

(3) Referrals

(4) Health education

c. Methods for preservation and storage:

(1) Dehydration – eliminates the moisture and prevents growth but does not kill bacteria.

(2) Canning and bottling – food is heated to high temperature to kill disease-producing germs.

Caution: Don't buy dented cans; they may contain germs.

(3) Pickling – salt, vinegar and spices used to preserve food.

(4) Freezing – prevents germs from growing. Some bacteria die of old age when food is frozen.

OBJECTIVES	CONTENT	ACTIVITIES
	(5) Irradiation (x-ray light waves are passed through foods)–used in "tender ray" beef. (6) Refrigeration. (a) Three days is the maximum time food should be left in refrigerator. (b) Frozen foods can be kept much longer. Consult a freezing guide for directions.	
	5. *Relationship of bacteria and viruses of food* a. Bacteria are one-celled plants, classed according to shape. (1) Bacilli are shaped like rods; they cause typhoid fever. (2) Cocci are ball-shaped; they cause strep throat and boils. (3) Spirilla are corkscrew shaped; they cause syphilis. b. Viruses are much smaller than bacteria and are neither plant nor animal. (1) Bacteria and viruses live in food and need warmth, moisture and food to grow. They produce waste products which can cause disease. (2) The change of color or texture of food is an indication that disease-causing organisms are present in the food. They multiply very rapidly.	
6. To gain an understanding of the four basic food groups.	6. *Food is divided into four (4) basic groups* a. Milk, b. Vegetables and fruits, c. Meat group, and d. Breads and cereals.	6. The trainer will show a chart of the four basic food groups. Group discussion. The professional nutritionist is to provide the teaching for this unit.
7. To gain an understanding of the influence of habit on good nutrition.	7. *Food habits* a. Good food habits begin at the infant's first feeding. b. The sooner a child is encouraged to have good food habits, the better his chances are for developing a normal eating pattern. c. Infants are very self-centered; they enjoy those things that give them pleasure and reject those that do not satisfy them.	7. The trainer introduces the subject of nutrition in a positive, optimistic way, with comments that reflect a positive view of the trainees. A professional nutritionist is to provide the teaching for this unit.

OBJECTIVES	CONTENT	ACTIVITIES
	d. They can be helped to develop a positive attitude toward food if the person feeding them is relaxed and happy. c. Once feeding time becomes an enjoyable time, the infant enjoys his food and is satisfied after eating. f. Once established, the positive attitude toward foods remains throughout life; the reverse is also true. g. In some cases certain types of foods are associated with pleasurable experiences and others with annoying experiences; the child consequently develops a habit of liking some foods and disliking others. h. The United States Department of Agriculture has shown by studies that bad food habits can be somewhat altered in adult life. i. The best means of altering bad food habits and promoting good food habits is education. THE FIVE BASIC NUTRIENTS	
1. To gain an understanding of the five basic nutrients.	1. *Fats* a. Functions: (1) Serves as a concentrated source of health and energy (2) Important for normal tissue functioning (3) Vehicle for the absorption of fat-soluble vitamins (4) Body insulator (5) Assists in the processing of proteins in the body (6) Helps to hold the body organs in position (7) Helps to maintain the body temperature. b. Sources: (1) Butter (2) Animal and vegetable oils (3) Bacon (4) Pork (5) Mayonnaise (6) Chocolate.	1. Combination of lecture and group discussion. Ask frequent questions.

c. Results of excessive intake:
   (1) Obesity
   (2) Too much weight on the skeleton
   (3) Associated with heart condition and shortened life span
   (4) Development of diabetes, high blood pressure.

d. Inadequate intake – lack of energy, fatigue.

2. *Carbohydrates*

a. Functions:
   (1) Source of health and energy
   (2) Spare the burning of proteins in the body
   (3) Assist in the body's utilization of fat
   (4) Assist in elimination.

b. Sources:
   (1) Flour
   (2) Potato
   (3) Sugar
   (4) Bananas
   (5) Dates
   (6) Oatmeal.

c. Excessive intake results in:
   (1) Increase in blood sugar
   (2) Obesity
   (3) Diabetes
   (4) Sugar in the urine (renal glycosuria)
   (5) Liver disease.

3. *Proteins*

a. Functions:
   (1) Build and maintain all body tissues: muscles, tendons, blood, skin, bone, nails
   (2) Help form glandular secretions such as hormones, digestive and other enzymes

(3) Provide food energy

(4) Help form antibodies to build resistance to disease.

b. Sources:

(1) Lean meats, poultry, fish

(2) Dry legumes

(3) Cheese, milk, and eggs

(4) Cereals and breads.

c. Protein deficiency results in:

(1) pellagra

(2) edema

(3) retarded growth

(4) weakness

(5) loss of vigor.

4. *Minerals*

a. Functions:

(1) Calcium:

(a) Helps build bones and teeth; keeps them rigid and strong

(b) Helps blood to clot

(c) Helps control muscular action, including beat of the heart.

(2) Iron:

(a) Is essential part of every blood and tissue cell

(b) Forms hemoglobin of the red blood cells, which carries oxygen to every body cell.

(3) Copper:

(a) Acts with iron in formation of hemoglobin.

(4) Iodine:

(a) As essential element of thyroxine, is necessary to normal functioning of thyroid gland

OBJECTIVES	CONTENT	ACTIVITIES
	(b) Controlling factor in basal energy metabolism. b. Sources: (1) Calcium: (a) Milk (b) Hard cheese (c) Greens, except spinach, beet, chard (d) Dry legumes (e) Citrus fruits (f) Eggs. (2) Iron: (a) Organ meats (b) Lean muscle meats (c) Dry legumes (d) Dark green leafy vegetables (e) Dried fruits (f) Eggs (g) Cereals, whole grain and enriched. (3) Copper: essentially the same foods that provide iron. (4) Iodine: (a) Iodized salt (b) Salt-water fish (c) Foods grown on iodine-rich soil (d) Water in nongoitrous regions. c. Mineral deficiencies: (1) Calcium: (a) Rickets (b) Weakness and weak bones (c) Poor teeth. (2) Iron: anemia.	

(3) Copper:

- (a) Anemia
- (b) Poor skin and hair pigmentation.

(4) Iodine:

- (a) Goiter (thyroid condition).

5. *Vitamins*

a. Functions:

(1) Vitamin A:

- (a) Helps keep outer skin and lining membranes intact and healthy to resist infection
- (b) Helps to maintain normal vision; protects against night blindness
- (c) Contributes to health, growth, and to tooth formation.

(2) Thiamine:

- (a) Helps convert sources of energy in the body into energy for work
- (b) Essential to good digestion and normal appetite
- (c) Necessary to a normally functioning nervous system.

(3) Riboflavin:

- (a) Helps cells use oxygen in providing body with energy
- (b) Contributes to smooth skin in nose-mouth area; protects against cracking at corners of mouth
- (c) Helps to keep eyes and lids healthy and vision clear.

(4) Niacin:

- (a) Helps translate sources of body energy into usable energy
- (b) Protects body against pellagra symptoms (skin lesions, inflammation of mucous membranes such as mouth, tongue and intestinal tract).

(5) Ascorbic acid:

- (a) Helps form a substance that binds living cells together; strengthens walls of blood vessels
- (b) Helps build body resistance to bacterial infection
- (c) Hastens healing of wounds.

b. Sources:

(1) Vitamin A:

- (a) Liver
- (b) Dark green leafy vegetables
- (c) Deep yellow vegetables (most) and fruits
- (d) Butter, fortified margarine, cream
- (e) Egg yolk
- (f) Whole milk.

(2) Thiamine:

- (a) Lean pork
- (b) Enriched and whole grain cereal products
- (c) Organ meats (liver)
- (d) Milk.

(3) Riboflavin:

- (a) Milk, cheeses
- (b) Liver
- (c) Muscle meats
- (d) Whole grain, enriched cereal products
- (e) Leafy green vegetables.

(4) Niacin:

- (a) Meats, poultry, fish
- (b) Peanuts, other nuts, dry beans and peas
- (c) Milk, eggs
- (d) Enriched and whole grains (except corn).

OBJECTIVES	CONTENT	ACTIVITIES
	(5) Ascorbic acid: (a) Citrus fruit juices (b) Strawberries (c) Cantalope (d) Tomatoes, juice (e) Potatoes (f) Dark green vegetables, including "greens." c. Vitamin deficiencies: (1) Vitamin A: (a) Lowers resistance to infection (b) Poor eyesight. (2) Thiamine: (a) Beriberi (pain in muscles, cardiac condition). (3) Riboflavin: (a) Cracking in corners of lips (b) Itching of eyes, burning, tearing. (4) Niacin: (a) Dermatitis (b) Mental deterioration (c) Diarrhea. (5) Ascorbic acid: (a) Scurvy (bleeding gums, loose teeth, failure of wounds to heal).	
6. To gain an understanding of the relationship of calories to good nutrition.	6. *The energy that results when food is burned is measured in terms of calories* a. A calorie is the unit of heat that will raise the temperature of two quarts of water 1°F. b. A calorie is not a nutrient. c. Proteins, fats, and carbohydrates produce energy which is measured in terms of calories. d. The body's heat comes from inside; evidence of this is that the body temperature remains relatively constant despite changes in temperature on the outside.	6. Combination of lecture and group discussion. Refer to trainee manual, p. 51 for additional material on nutrition, meal planning, and food purchasing.

e. The caloric content of food can be measured.

f. Fat yields more than twice the number of calories produced by similar amounts of protein and carbohydrates.

g. It is the excess of calories that causes a person to become obese.

h. Caloric needs are higher for pregnant women and growing children than for others.

i. In order to be well nourished, a person must have an adequate intake of calories.

j. The body uses energy in three ways:

   (a) Basic functions of the body – heartbeat, circulation, digestion

   (b) Voluntary movements of the body – walking, swimming

   (c) Storage of energy-producing materials during period of growth.

Films on Nutrition

All materials can be obtained from the United States Government Printing Office, Washington, D. C.

1. *Planning for Good Eating* (motion picture) U.S. Office of Inter-American Affairs, 1945. Made by Walt Disney Productions. Re-released by U.S. Institute of Inter-American Affairs, 1946.

2. *The Wonderful World of Food* (motion picture) U.S. Office of Civil Defense. Made by U.S. Army Signal Corps. Released by American National Red Cross, 1962.

3. *Food for Fitness* (filmstrip) U.S. Department of Agriculture.

4. *Cooking Good Meals* (filmstrip) U.S. Public Health Service, 1950.

5. *Eating for Good Health* (filmstrip) U.S. Public Health Service, 1950.

6. *Planning Good Meals* (filmstrip) U.S. Public Health Service, 1950.

7. *Selecting Meals for All Occasions* (filmstrip) U.S. Public Health Service, 1950.

8. *Food Storage* (motion picture) U.S. Department of the Army, 1949. Released for public educational use through U.S. Office of Education, 1949.

9. *Food Conservation: The Dollars and Sense of Good Eating* (motion picture) U.S. Department of the Army, 1958.

In addition, the film *Food, The Color of Life* (22½ minutes, for use with the *Teacher-Leader Guide,* 4 pages, 10¢) is available from Association Films, Inc., at the following addresses.

25358 Cypress Avenue
Hayward, California 94544

2221 South Olive Street
Los Angeles, California 90007

2227 Faulkner Road, N.E.
Atlanta, Georgia 30324

561 Hillgrove Avenue
La Grange, Illinois 60525

490 King Street, Box 188
Littleton, Massachusetts 04160

600 Grand Avenue
Ridgefield, New Jersey 07657

324 Delaware Avenue
Oakmont, Pennsylvania 15139

1621 Dragon Street
Dallas, Texas 75207

I. ACCIDENTS

Overall Objective:

To gain an understanding of the problem of accidents, the fourth leading cause of death in the United States.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To understand the comprehensive meaning of accident.	1. Accident – an event occurring by chance that causes harm or destruction. 2. Fourth leading cause of death. a. Most frequent cause of death for age group 1-34. 50% of accidental deaths in this age group occur between the ages of 15 and 25 (auto most likely cause). b. Rate of death from accidents is increasing. c. Accidents in the home account for more than 50% of all accidents. d. Leading causes of accidental death are: autos, falls, fires, explosions, and drownings. 3. Men have more accidents than women. 4. The aged have three times the accident rate for the population as a whole. 5. Auto accidents. a. Pedestrian deaths – 4,000 per year. b. Accident rate for males four times the rate for females. c. Death rate for males three times the rate for females. d. Most auto accidents occur less than 10 miles from home and at a speed of 40 mph or less. e. Seat belts and shoulder belts are the best way to prevent certain injuries. 6. Poison and accidents. a. Almost everything is a potential poison if taken in sufficient quantity. b. Antidote – a remedy to counteract the effects of a poison.	1. Lecture and group discussion. If accident prevention specialist is available in local community his services should be obtained to provide lecture. The accident prevention specialist or health aide trainer to provide demonstrations on faulty wiring, explosions with household chemicals, improper use of space heaters, wringer washing machines, and other common household appliances that may constitute hazards.

c. The most common causes of poisoning are medicines, cleaning and polishing agents, petroleum products, pesticides, turpentine, paints, and cosmetics.

    (1) Iron tablets are particularly dangerous to children.

    (2) Kerosene poisoning – the symptoms are not immediately apparent.

    (3) Acids – use baking soda as an antidote.

    (4) Lyes, caustics – administer water or milk as an antidote.

d. Almost all accidental death due to poison occurs in children under five years of age.

e. Many plants are poisonous. Examples: azalea leaves, lily of the valley, holly berries, rhododendron, tulip bulbs.

f. How to poison-proof a home.

    (1) Keep all household medicines and poisonous products out of reach of children.

    (2) Store medicines separately from household products and keep them in their original containers.

    (3) Label items properly; read label carefully before using.

    (4) Turn lights on when taking or administering medicines.

    (5) Do not take medicines around children.

    (6) Clean out medicine cabinet periodically and destroy all old medicines.

7. Fire and accidents.

    a. Causes of fires in the home:

        (1) Faulty wires

        (2) Gasoline explosions

        (3) Cigarettes

        (4) Kerosene heaters.

    b. Fire prevention.

        (1) Gasoline should never be kept in the home.

(2) Gasoline should never be stored in a jar.

(3) Kerosene is ten times more explosive than gasoline.

(4) No portable space heaters. They give off carbon monoxide.

(5) Never spray insect killers around fire.

(6) Never spray paint around fire.

(7) Do not puncture pressurized cans.

(8) Wiring.

  (a) If wiring system is overloaded, the fuse blows out. If fuse is replaced with a higher amperage fuse, a fire results. Also, a fire can result from overloading a wiring system.

  (b) Never replace fuse with the wrong amperage.

  (c) Call electrician if more power is needed.

  (d) Do not try to improvise.

c. Putting out fires in the home.

  (1) Never throw flour on fire, because it explodes.

  (2) Baking soda will put out fire.

  (3) Salt will put out fire if nothing else is available.

  (4) If cooking and fire starts, turn off flame or electricity and cover pot to smother fire.

  (5) Call the fire department in the case of any potentially dangerous fire.

Films and Filmstrips on Accident Prevention

These materials can be obtained from the United States Government Printing Office Washington, D. C. Some of them can be ordered in quantity and distributed to trainees.

1. *Know Your Fire Hazards* (motion picture) U.S. Department of the Navy, 1958. Made by Audio Productions.

2. *The Nature of the Fire* (motion picture) U.S. Department of the Navy, 1958. Made by Audio Productions.

References on Accident Prevention

1. Dietrich, H.F.: "Clinical Application of the Theory of Accident Prevention in Childhood," *Am. J. Pub. Health* 42:849, July, 1952.

2. Prothro, W.B.: "Home Accident Prevention," *A. M. J. Pub. Health* 41: 954, Aug. 1951.

3. Phillips, E.C.: "Home Accident Prevention, The Role of the Public Health Nurse," *A.M.J. Pub. Health,* 40: 517, May 1950.

4. Press, E.: "Epidemiological Approach to Accident Prevention," *Am. J. Pub. Health* 38:1442, Oct., 1948.

5. "The Public Health Problem of Accidental Poisoning, A Symposium," *Am. J. Pub. Health* 49:951, Aug. 1956.

6. Bradley, J.E. and Bessman, S.P.: "Poverty, Pica, and Poisoning," *Pub. Health Rep.* 73:467, May, 1958.

7. Press, E. and Mellins, R.B.: "A Poisoning Control Program," *Am. J. Pub. Health* 44:1515, Dec. 1954.

8. Conn, H.M.: "Control of Accidental Poisoning, A Progress Report," *J.A.M.A.* 168: 717, Oct. 11, 1968.

Accident Prevention

1. *Accidents and Children.* Rev. 1963. 20 p. illus. 15¢

2. *Children and Neglect, Hazardous Home Conditions.* 1963. 59 p. 40¢

3. *Families On Guard Against Accidents.* 1963 (6) p. illus. 5¢

4. *Fundamentals of Accident Prevention.* 1962. 14 p. 15¢

5. *Play it Safe.* 1964. 2 p. illus. 5¢

6. *Preventing Child Entrapment in Household Refrigerators.* 1964. 8 p. illus. 5¢

7. *Watch Your Step, Avoid Farm Accidents.* Rev. 1960. 24 p. illus. 15¢

Lead Poisoning

1. *Recognition of Lead Poisoning in the Child.* 1958. 8 p. 10¢

J. EPIDEMIOLOGY

Overall Objective:

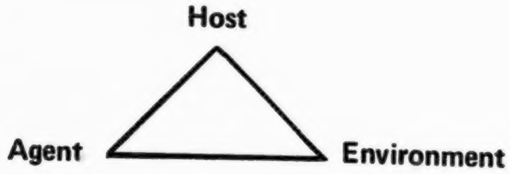
To gain an understanding of epidemiology and its use in determining the factors associated with disease conditions.

OBJECTIVES

1. To gain an understanding of the definition of epidemiology and the meaning of the classical triad.

CONTENT

1. *Definition of epidemiology*
   a. Greek stems.
      (1) "epi"–upon
      (2) "demos"–people
      (3) "logos"–knowledge of
   b. Greek stem interpretation.
      (1) Knowledge of what happens to the people.
   c. The science which concerns itself with the study of disease as it is found in groups of persons related by some common factors such as age, heredity, sex, or race, as distinct from the study of disease in individuals.
   d. The science that deals with the causes of a disease or pathological condition in an individual or group.
   e. Classical triad:



2. *Factors which affect susceptibility of host to disease*
   a. Genetic characteristics, such as an inherited susceptibility to cerebral palsy or PKU.

ACTIVITIES

1. Trainer questions to obtain answers from students. If possible, an epidemiologist from the public health agency should be invited to lecture on this topic.

Trainer draws the triad on the board. Trainer tells the class that each element has a direct influence on the other two. Trainer tells class that each element of the triad can be affected by a number of factors. Students are asked to give examples of these factors.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
	b. Sexual factors, such as male susceptibility to color blindness. c. Age: old people are susceptible to arteriosclerosis; children are susceptible to chicken pox. d. Physiological factors such as stress, fatigue, and nutrition influence susceptibility. e. Immunization, such as influenza and tetanus shots, can decrease susceptibility.	
	3. *Agents that cause disease* a. Specific disease-causing organisms: (1) Bacteria (a) Streptococcus (b) Gonococcus (2) Protozoa (a) Malaria (3) Virus (a) Influenza (b) Poliomyelitis (c) Hepatitis (4) Fungus (a) Thrush in the newborn (b) Coccidioidomycosis (5) Metazoa (a) Trichina (b) Hookworm (6) Rickettsiae (a) Typhus fever (b) Rocky Mountain spotted fever. b. Chemical agents. (1) Paint: lead poisoning. (2) Smoke: asphyxiation. (3) Radiation: burns, nausea, cancer.	3. Trainer asks students to give examples. Trainer will supply all mentioned factors not given by students.

OBJECTIVES

CONTENT

ACTIVITIES

- (4) Acid: burns, allergies.
- (5) Alkali: burns.
- (6) Tar in cigarettes: lung cancer.
- (7) Others: carbon tetrachloride (cleaning fluid) – destruction of white blood cells.

c. Physical agents, such as

- (1) Pipes: pipe smokers may develop lip and tongue cancer resulting from chronic irritation of the mouth.
- (2) Heavy objects: the lifting of heavy objects may overstrain part of the body, resulting in a hernia.
- (3) Airplanes, automobiles, loose rugs, and broken glass may cause accidents and thus are possible agents of disease.

d. Nutritional agents.

- (1) An overabundance of cholesterol may contribute to the development of CVD.
- (2) An insufficiency of vitamins and minerals in the diet may cause disease.
  - (a) Scurvy results from a lack of vitamin C.
  - (b) Anemia results from a lack of iron.
- (3) Caloric intake.
  - (a) Too many calories in the diet cause obesity.
  - (b) Too few calories in the diet cause malnutrition.

4. *Environmental factors that may contribute to development of a disease*

a. Poor garbage disposal–multiplication of germs.

b. Poor human waste disposal – the possibility of typhoid fever is enhanced.

c. Poor food handling–staphylococcus, salmonella.

d. Rodents – bites and tetanus.

e. Air pollution – emphysema, asthma, and cancer.

4. Select a sample block in area served by agency. Observe, record, and report on environmental hazards.

f. Geographic factors.

(1) Mineral content of soil and water may affect the content of minerals in fish and plants and thus affect the diet.

(2) May affect availability of certain types of foods.

(3) May influence the probability of a specific disease-causing agent being in the environment.

(a) Malaria absent in Alaska.

(b) Smallpox nearly absent in the United States.

(c) Cholera endemic to India.

g. Seasonal factors: certain disease-causing agents are particularly prevalent in the environment during certain seasons. Examples: The common cold and influenza during the fall; pollen during the spring and summer.

h. Climatic factors.

(1) May affect the availability of certain types of foods; fresh vegetables difficult to find in cold climates.

(2) Certain kinds of climates may activate certain conditions: there is a greater incidence of asthma in damp climates.

i. Conditions at school.

(1) Faulty play equipment

(2) Overcrowding

(3) Faulty ventilation

5. *Summary*

a. Be sure to stress in summary that epidemiology is concerned with both infectious and noninfectious agents.

References on Epidemiology

1. *Control of Communicable Diseases in Man.* 9th ed., American Public Health Association, New York, 1960.
2. World Health Organization. *Epidemiological and Vital Statistics Report.* Volume 13, 1960, p. 527.
3. Anderson, Gaylord W. and Arnstein, Margaret G. *Communicable Disease Control,* The Macmillan Company, New York,1953.
4. Maxcy, Kenneth F. *Rosenau's Preventive Medicine and Hygiene,* 8th ed., Appleton - Century - Crofts, Inc., New York, 1956.

K. SELECTED CHRONIC DISEASES

Overall Objective:

To gain an understanding of the cause, prevention and treatment of selected chronic diseases.

OBJECTIVES

1. To gain an understanding of the meaning of chronic diseases and the causes, symptoms and treatment of selected chronic diseases.

CONTENT

1. *Definition of chronic disease. Any condition characterized by one of the following:*
   a. Residual disability
   b. Permanent defect
   c. Irreversibility
   d. Long period of care needed
   e. Rehabilitation may be needed.
2. *The relationship of important chronic diseases to the ten (10) leading causes of death.*
   *1. Heart
   *2. Cancer
   *3. Vascular diseases of the central nervous system
   4. Accidents
   5. Diseases of early infancy
   6. Pneumonia and influenza
   *7. General arteriosclerosis
   *8. Diabetes
   9. Congenital defects
   *10. Cirrhosis of the liver.
3. *Effects of chronic disease on family and individual:*
   a. Financial burden
   b. Change in personality of individual
   c. May cause isolation or ostracism of chronically ill persons from family
   d. Fear of death and/or disability

* chronic disease

ACTIVITIES

1. Lecture. Group discussion by internist or general practitioner in the local community.

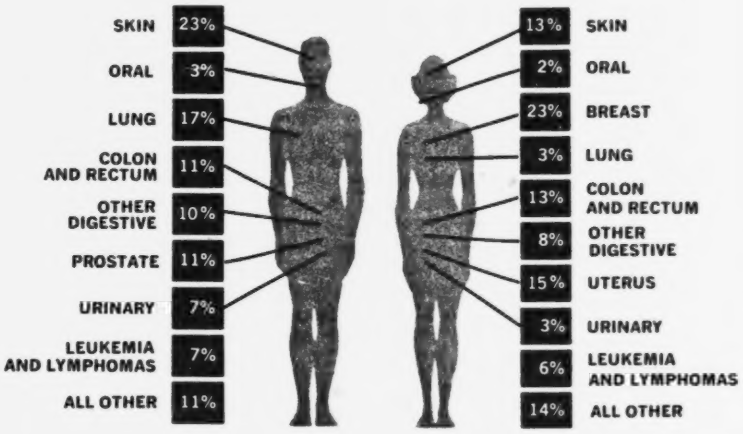
Display charts and drawings as frequently as possible.

Invite questions and examples known to trainees as a result of their personal contacts with neighbors and relatives. Prior to initiation of this unit (or in advance of training), all trainees should receive a complete medical examination which should include such items as proctoscopy, pap smear, chest x-ray, blood test and others used for early detection of chronic diseases. Discuss tests in relation to the concept of prevention and early detection.

Use films and filmstrips on chronic diseases from local, private and public health agencies.

- e. Fear of inheriting and/or passing on characteristic of chronic disease
- f. Fear of loss of earning power
- g. Fear of recurring symptoms
- h. Fear of becoming an invalid.

4. *Causes, symptoms and treatment of cancer*
   - a. All of the causes of cancer are not known.
   - b. The known causes of cancer can vary with the different areas of the body affected.
   - c. Some factors that appear to be associated with causing cancer:
     - (1) Heredity
     - (2) Chronic irritation
     - (3) X-rays
     - (4) Overexposure to sunlight
     - (5) Radium
     - (6) Smoking
     - (7) Viruses
     - (8) Hormones.
   - d. Cancers are classified according to type of cell of origin.
     - (1) Sarcomas are cancers arising from connective and supportive tissue, such as bone, cartilage, nerve, and fat.
     - (2) Carcinoma, which includes the majority of the forms of human cancer, is cancer arising from epithelial tissue such as skin and the lining of the body cavities and organs, and glandular tissue, such as the breast or prostate.
     - (3) Leukemia, a third and less prevalent form, is cancer involving blood-forming tissues.
   - e. There are two types of neoplasms (new growths of tissue serving no healthy function):
     - (1) Benign neoplasm spreads to the surrounding tissues, but is usually harmless; can be harmful in brain because of pressure on surrounding brain tissue.



CANCER INCIDENCE BY SITE AND SEX

(2) Malignant neoplasm spreads past original site; can metastasize or travel to new site by:

(a) Lymphatic system

(b) Blood stream

(c) Direct extension into surrounding area.

f. Seven (7) danger signals of cancer:

(1) Unusual bleeding or discharge

(2) A lump or thickening in the breast or elsewhere

(3) A sore that does not heal

(4) Change in bowel or bladder habits

(5) Hoarseness or cough

(6) Indigestion or difficulty in swallowing

(7) Change in wart or mole.

g. Treatment:

(1) There are three (3) recognized forms of cancer treatment: surgery, radiation, and drugs.

(2) The choice of treatment depends on the type, location, and stage of the disease.

(3) Two or three methods can be used for the same patient.

(4) Cure depends upon destruction of the cancerous cells.

(5) Early cases can be cured by radiation.

(6) No drugs have been found that will cure cancer.

(7) Five years has been generally adopted as the standard yardstick for cancer cures.

(8) Beware of quacks.

5. *Causes, symptoms, and treatment of diabetes*

a. The actual cause of diabetes is unknown, although certain types of people are more likely to develop the disease.

(1) Persons who come from a diabetic family:

(a) Tendency to contract the disease is inherited.

(b) Most diabetics are not born with the disease, but contract it later in life.

(c) The earlier the disease develops, generally, the more severe.

(2) Persons over forty:

(a) About 5% of diabetics develop the disease before 15 years of age.

(b) The incidence is 5 times greater past the age of forty.

(3) Persons overweight:

(a) Overeating places a strain on the pancreas (the gland that produces insulin).

b. Symptoms (*most common):

*(1) Excessive thirst

*(2) Frequent urination

*(3) Excessive hunger

*(4) Loss of weight

(5) Failing eyesight

*(6) Intense itching

(7) Pain in fingers and toes

(8) Weakness, tiring easily, and drowsiness.

c. Diabetes is a condition in which the body does not supply enough insulin to break down certain foods.

(1) The insulin released by the pancreas regulates the rate at which the body cells use sugar.

(2) Much food that is eaten is converted to sugar; all of the carbohydrates; 50 percent of protein; 10 percent of fat.

(3) If more sugar is present than is needed, it is stored.

(4) When a person has diabetes, the cells cannot properly use the sugar, and the liver and muscles cannot store the sugar.

(5) The food is still converted to sugar; sugar passes out in the urine and accumulates in the blood.

(6) The symptoms of diabetes are related to excess amounts of sugar in the blood and urine.

d. Treatment of diabetes.

(1) The mild diabetic can manage on diet control.

(2) Some persons are treated with diet and pills.

(3) Some persons require diet, pills, and insulin.

(4) Others require diet restriction and insulin.

6. *Hypertension, arteriosclerosis, cerebral vascular accidents, and some cardiac conditions*

a. Blood pressure varies from day to day and from minute to minute.

(1) Blood pressure elevates during excitement and descends during rest or sleep.

(2) These changes happen in all persons.

b. High blood pressure (hypertension).

(1) In this country, approximately five million people are hypertensive and can be helped with proper medical care.

(2) Hypertension works on the heart and arteries.

(a) The heart must pump with increased force.

(b) If high blood pressure exists for a long period of time, improper functioning of the heart and arteries may occur.

(3) Hypertension is not necessarily a serious disease.

(4) If hypertensive patients are properly cared for, they may look forward to many years of comfortable and productive living.

(5) There are no precise symptoms of hypertension.

(6) Many people with hypertension have no symptoms at all.

(7) Headache, dizziness, and fatigue may be associated with hypertension.

c. Arteriosclerosis – hardening of the arteries:

(1) Arteriosclerosis and hypertension sometimes go together, but not always.

(2) The cause of arteriosclerosis has not been determined but is associated with age.

(3) Arterioclerosis can be detected by an eye examination or a routine physical checkup.

(4) Blood is sometimes slowed up because of a thickening of the arteries that goes along with the hardening process.

d. Accidents to the blood vessels – this results after many years of hypertension or when the arteries have become brittle from arteriosclerosis.

(1) Small arteries may break, or if their walls become too thick the flow of blood may stop.

(2) If blood slows up too much in big arteries the blood may clot.

(3) Stroke or apoplexy result when a small artery in the brain bursts or is completely clogged.

(4) The medical terms are cerebral hemorrhage or cerebral thrombosis.

(5) The results of the accident may range from temporary paralysis, involving a part or half of the body, to complete and permanent paralysis ending in death.

(6) The extent and gravity of the accident depends on the amount of brain damage.

e. When the heart's arteries are affected, circulatory accidents may occur in the blood vessels that feed the heart, either partially or completely shutting off the blood supply to some parts of the heart.

(1) The vascular accident is called coronary heart disease.

(2) Coronary heart disease may begin with a sharp, constricting pain around the breastbone which spreads to the shoulder or neck.

f. Prevention and treatment of hypertension, arteriosclerosis, cerebral vascular accidents, and some heart diseases.

(1) Try not to worry.

(a) Worry, nervous tension, and emotional upsets help raise blood pressure.

(2) Keep your weight normal.

(a) Overweight is a health hazard.

(3) Avoid work involving continuous pressure.

(4) Follow directions of physician on smoking and drinking.

(a) Smoking raises blood pressure in some patients.

(b) Alcohol does not raise blood pressure. Although it may reduce nervous tensions, it cannot be recommended as a treatment for hypertension.

(5) Proper sleep:

(a) Take short naps during the day.

(b) Blood pressure is lowest during sleep and rises during working hours.

(6) Rest before you get tired.

(a) Rest will avoid tenseness and irritability.

7. *Arthritis and rheumatism*

a. Rheumatic disease.

(1) Rheumatic disease is called arthritis when it attacks the joints.

(2) Arthritis is the most common and oldest known chronic disease.

(3) The effects of arthritis range from slight pain through stiffness, swelling, crippling, and possible disability.

(4) Arthritis is the nation's number one crippler.

(5) Approximately 13 million Americans suffer from its effects.

(6) Some become completely disabled. Others are able to continue keeping house, engage in outside activity and also to continue to work on their jobs.

(7) A rheumatic disease may strike at any time and at any age.

(8) Arthritis accounts for 186 million days of restricted activity and 12 million days lost from work. It costs the nation over a billion dollars a year in medical expenses, relief, and lost wages.

b. The cause.

(1) The cause or causes are not known.

(2) Some cases may result from sprains, infections, or joint injury.

(3) Many scientists suspect viruses or bacteria, allergy, the nervous system or the hormones, but this may not necessarily be true.

(4) Others suspect a disorder of the metabolic system.

(5) It is not thought that emotional shock can bring on arthritis or an attack of rheumatism.

(6) Attacks often follow changes in the weather.

c. Rheumatoid arthritis.

(1) About one third of those who visit and are treated by a physician is diagnosed as having rheumatoid arthritis.

(2) Rheumatoid arthritis usually starts between the ages of 25 and 50.

(3) It causes inflammation and thickening of the lining of the joints.

(4) This lining may grow into the joint space and fill it.

(5) The cartilage that covers the ends of the bones may become eroded.

(6) The bones may grow together, and the joint becomes permanently fused.

(7) The first signs of rheumatoid arthritis are fatigue, muscular stiffness, and a loss of appetite and weight.

(8) Painful swelling may start at the joints; nodules may appear under the skin; muscular wasting and spasm frequently occur.

(9) The disease may affect various organs and is sometimes accompanied by fever.

(10) Although there is no cure for such a disease, proper medical treatment may prevent severe crippling.

(11) In some patients, despite treatment, the disease may lead to chronic disability and sometimes complete crippling.

(12) Many sufferers can be aided by simple measures such as rest, corrective exercises, physical therapy, and aspirin.

d. Osteoarthritis.

(1) Osteoarthritis is a degenerative joint disease and results from aging, irritation of the joints, and normal wear and tear.

(2) It is less damaging than rheumatoid arthritis.

(3) It occurs most frequently in older people, affecting nearly everyone over 50 and causing pain to 1 out of 20.

(4) Chronic irritation of the joints is the main contributing factor, and can result from overweight, poor posture, injury, or strain from occupation or recreation.

(5) The disease is characterized mainly by degeneration of joint cartilage that becomes soft and wears unevenly.

(6) In some cases, it may wear away completely and thickening of the ends of the bones may occur.

(7) The remainder of the body is seldom affected.

(8) If the hip joints or knees are involved, a little serious deformity or crippling may occur.

(9) Common symptoms are pains, aches, and stiffness.

(10) Pain is experienced when the joints are pressured by weight.

(11) Enlargement of the fingers at the last joint often occurs.

(12) Permanent enlargements of this type seldom lead to disability.

e. Gout.

(1) This disease affects the joints of the feet, especially the big toe.

(2) A susceptibility to it is inherited, and it occurs mostly in men.

(3) This disease may result from minor injury, excessive eating or drinking, heavy exercise, or surgical operations.

(4) Often, attacks occur with no apparent provocation.

(5) The patient may have acute joint inflammation which may last for several days or weeks.

(6) Many years after the onset, chronic arthritis may set in.

(7) Controlled with medication.

f. Fibrositis.

(1) Fibrositis is the most common rheumatic condition that does not affect the joints.

(2) It is characterized by pain, stiffness or soreness of fibrous tissue, especially in the muscle coverings.

(3) Attacks may follow injury, repeated muscular strain, prolonged mental tension or depression.

(4) Fibrositis within the muscles is sometimes called myositis.

(5) Lumbago is fibrositis in the lumbar region and low back.

(6) This condition may disappear spontaneously or respond well to treatment, but some cases may persist for years.

(7) Chronic sufferers are rarely crippled.

g. Treatment.

(1) Rheumatic disease should be treated by a physician or under his supervision.

(2) Self-treatment may be harmful.

(3) In all rheumatic diseases, rest and freedom from mental strain are desirable.

(4) Physicians advice to patients with these diseases may be: a well-balanced diet, application of heat, mild exercises, corrected posture, and avoidance of cold and dampness.

(5) There is no scientific evidence that hot springs, mineral waters, or a warm, dry climate are more beneficial than proper care at home.

(6) The established forms for the treatment of rheumatoid arthritis are:

   (a) Physical and emotional rest

   (b) Physical therapy, such as heat and corrective exercises

   (c) Aspirin in adequate amounts

   (d) Other drugs

   (e) Corrective surgery.

8. *Importance of early detection and treatment of all chronic diseases*

   a. May reverse effects of disease on person.

   b. Prevent complications and debilitating effects.

   c. Chances are better for individual to lead a normal life.

   d. Generally treatment is less expensive in the long run if begun early.

   e. May prevent death.

Films and Filmstrips on Chronic Diseases

These materials can be obtained from the United States Government Printing Office, Washington, D.C. Some of them can be ordered in quantity and distributed to trainees.

1. *Breast Cancer: The Problem of Early Diagnosis* (motion picture) American Cancer Society and U.S. National Institute of the U.S. Public Health Service, 1949. Made by Audio Productions.
2. *Breast Self-Examination* (motion picture) American Cancer Society and National Cancer Institute of the U.S. Public Health Service, 1950. Produced by Audio Productions.
3. *Cancer Education* (motion picture) U.S. Dept. of the Army, 1950. Made by Melia Productions. Released for public educational use through U.S. Office of Education, 1950.
4. *Choose to Live* (motion picture) U.S. Public Health Service, 1940. Made by U.S. Dept. of Agriculture.

References on Chronic Diseases

1. "Distribution of Health Services in the Structure of the State Government." *Public Health Reports* 37:155, Feb. 1947.

2. "Health Statistics on Currently Employed Persons, Illness and Work Day Loss," *Public Health Service Bill.* No. 584-c7, April, 1962.
3. "Planning for the Chronically Ill." Joint Statements of Recommendations by the A.H.A., A.M.A., P.A.A. and the A.P.W.A., *Am. J. Pub. Health* 37:1256. October, 1947.
4. "National Health Forum on Chronic Disease," *Publ. Health Rep.* 71:675. July, 1956.
5. *Commission on Chronic Illness: I. Chronic Illness in the United States, II. Care of the Long Term Patient, III. Chronic Illness in a Rural Area, IV. Chronic Illness in a Large City.* Cambridge 1957, Harvard University Press.

Heart and Circulatory System

1. *A Living Pump, the Heart and Blood Cycle* (colored poster showing the functions of the circulatory system). Rev. 1961. (11 x 17 in.).
2. *Cerebral Vascular Disease and Strokes,* Rev. 1964. 15 p. illus. 15¢
3. *Circulatory System, Normal and Abnormal Conditions,* Rev. 1963, published 1964. 59 p. illus. 45¢
4. *Coronary Heart Disease in Adults, United States, 1960-62.* 1965. 46 p. illus. 35¢
5. *The Food You Eat and Heart Disease.* Rev. 1963. 12 p. illus. 10¢
6. *Hardening of the Arteries, Cause of Heart Attacks.* 1966. 12 p. illus. 10¢
7. *Heart Disease in Children, Training Program in Cardiology, Proceedings Workshop.* University of Colorado Medical Center, Denver, Colo., Dec. 3-6, 1962. 1966. 74 p. 35¢
8. *How Doctors Diagnose Heart Disease.* 1965. 12 p illus. 10¢
9. *Smoking and the Heart Related to Smoking and Health.* Report of the Advisory Committee to the Surgeon General of the Public Health Service. 1964. 4 p. illus. 5¢

Alcoholism

1. *Alcoholism.* Rev. 1965. 16 p. 10¢
2. *Alcoholism: Community Agency Attitudes and Their Impacts on Treatment Services.* 1965. 54 p. 40¢

Mental Health

1. *Child Who Is Mentally Retarded.* 1956. 24 p. illus. 10¢
2. *Mental Disorders of the Aging.* 1963. 20 p. illus. 20¢
3. *Mental Illness Among Older Americans* 1961. 20 p. 15¢
4. *Mental Illness and Its Treatment, Past and Present.* 1965. 18 p. illus. 20¢

Cancer

1. *Breast Self-Examination.* Reprinted. 1958 8 p. illus. 10¢
2. *Can You Answer These Questions?* 1964. 4 p. illus. 10¢
3. *Cancer: A World Menace. Some Facts and Figures on its Occurrence in the United States and Abroad.* 1959. 40 p. illus. Pl. map. 40¢
4. *Cancer Cause and Prevention, Environmental Factors, Personal Factors, Occupational Hazards.* 1962. 16 p. 10¢

5. *Cancer in Subhuman Primates.* 1964. 61 p. 25¢
6. *Cancer Manual for Public Health Nurses*. 1963. 112 p. illus. 55¢
7. *Cancer of the Bone*. 1963. 6 p. 5¢
8. *Cancer of the Breast*. Rev. 1966. 6 p. illus. 5¢
9. *Cancer of Colon and Rectum*. 1965. 5 p. illus. 15¢
10. *Cancer of the Larynx.* 1965. 6 p. 5¢
11. *Cancer of the Lung*. Rev. 1966. 10¢
12. *Cancer of the Mouth*. 1966. 6 p. 5¢
13. *Cancer of the Skin*. Rev. 1963. 8 p. 5¢
14. *Cancer of the Stomach*. 1964. 8 p. 5¢
15. *Cancer of the Uterus*. Rev. 1965. 6 p. 5¢
16. *Cancer Programs of the U.S. Public Health Service*. 1966. 22p. illus. 20¢
17. *Cancer Rates and Risks.* 1964. 93 p. illus. 40¢
18. *Questions and Answers about Urine Cancer*. Rev. 1966. 6 p. illus. 5¢
19. *Smoking and Cancer,* related to *Smoking and Health,* Report of the Advisory Committee to the Surgeon General of the Public Health Service. 1964. 6 p. illus. 5¢
20. *Smoking and Oral Cancer*, excerpts from *Smoking and Health,* Report of the Advisory Committee to the Surgeon General of the Public Health Service. 1964. 12 p. 15¢
21. *Teaching Guide, Science and Cancer.* 1966. 24 p. illus. $2.25.
22. *Treating Cancer, Surgery, Radiation, Chemotherapy.* 1960. 16 p. illus. 15¢

Diabetes

1. *Are You Related to a Diabetic?* Rev. 1964. 4 p. illus. 5¢
2. *Diabetes*. Rev. 1964. 6 p. 5¢
3. *Diabetes Fact Book.* 1962. 34 p. illus. 30¢
4. *Footcare for the Diabetic Patient.* 1964. 6 p. 5¢
5. *Taking Care of Diabetes.* Rev. 1963. 35 p. illus. 20¢

Arthritis

1. *Arthritis and Rheumatism.* Rev. 1965. 8 p. 5¢
2. *The Nurse and the Arthritic.* 1964, reprinted 1965. 6 p. illus. 5¢
3. *Rheumatoid Arthritis in Adults: United States, 1960-62.* 35¢

Heart Disease

1. *Congestive Heart Failure.* 1964. 40 p. 20¢

2. *Congestive Heart Failure, A Guide for the Patient.* 1963. 12 p. 10¢
3. *Coronary Artery Disease.* Reprinted 1965. 5 p. Out of Print.
4. *The Food You Eat and Heart Disease.* Rev. 1963. 12 p. illus. 10¢
5. *Handbook of Heart Terms.* 1964. 66 p. illus. 30¢
6. *Hardening of the Arteries, Cause of Heart Attacks.* 10¢
7. *Heart Disease in Children, Training Program in Cardiology, Proceedings Workshop.* Dec. 3 - 6, 1962, Denver, Colo. 1966. 74 p. 35¢
8. *High Blood Pressure.* Rev. 1964. 6 p. 5¢
9. *Rheumatic Fever and Its Prevention.* 1964. 6 p. illus. 5¢
10. *Sickle Cell Anemia.* 1965. 8 p. illus. 5¢

NOTE: It is recommended that the local unit of the American Cancer Society, American Heart Association, and other health agencies be contacted for other professional teaching audiovisual materials.

L. INFECTIOUS DISEASES

Overall Objective:

To gain an understanding of infectious disease.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To gain an understanding of infectious diseases, their symptoms and treatment.	1. The material to be presented in this unit will be found in the trainee manual.	1. The trainer is referred to the trainee manual, p. 69, for the material to be covered. A combination of lecture and group discussion should be used. The communicable disease officer in the agency that will be employing health aides will come to a class session and discuss the communicable disease problem as he sees it in the local community. Also, he will discuss techniques of early detection and prevention as they operate in the agency. Explain the roles of the PHN, health educator, laboratory technician, and physician, and relate these roles to prevention, detection, and treatment of infectious diseases. Each health aide will review the immunizations obtained by each member of his family. From this listing, the health aide is to develop a plan to bring family members up to the optimum level if they fall below it. The trainees

should then implement the plan.

Trainees should discuss their experience with any of the diseases discussed, emphasizing the symptoms they may have noticed.

When discussing particular diseases, visit the laboratory of the public health department and observe various organisms by looking through the microscope. Observe cultures for various microbes, especially those for venereal diseases. Re-emphasize the important role which the laboratory staff plays in communicable disease control.

References on Infectious Diseases

The following materials can be obtained from the United States Government Printing Office, Washington, D. C. Some of them may be obtained in quantity to be distributed to trainees.

1. Christensen, A. W., Flook, Evelyn and Druzina, G. B., "Distribution of Health Services in the Structure of State Government," Washington, 1953, *Public Health Service Publ.* No. 184, Part 3.

2. Emerson, Haven. "Uniformity in Control of Communicable Disease," *Am. J. Pub. Health* 29:701, July 1939.

3. *Control of Communicable Disease in Man,* 9th ed., American Public Health Assoc., New York, 1960.

Infectious Diseases

1. *Poliomyelitis (Infantile Paralysis)* 10¢

2. *Mumps* 5¢

3. *Measles (Rubeola)* 5¢

4. *Smallpox* 5¢

5. *Common Cold* 5¢

6. *Rabies* 5¢

7. *Tuberculosis Today* 10¢

8. *Influenza* 5¢

9. *Diphtheria* 5¢

10. *Chicken pox* 5¢

11. *Malaria* 5¢

12. *Tetanus (Lockjaw)* 5¢

13. *Whooping Cough* 5¢

14. *Syphilis and Gonorrhea* 5¢

Tuberculosis

1. *The Development of Present Knowledge about Tuberculosis.* 1961, 11p. 10¢

2. *Tuberculosis Today.* Rev. 1966, 8 p. 10¢

Rheumatic Fever

1. *The Child with Rheumatic Fever.* 1955. 14 p. illus. 10¢

2. *Rheumatic Fever and Its Prevention.* Rev. 1964, 6 p. illus. 5¢

Venereal Diseases

1. *About Syphilis and Gonorrhea.* Rev. 1961, reprinted 1964. 5¢

2. *Eradication of Syphilis, A Task Force Report to the Surgeon General,* Public Health Service, 1962. 25¢

3. *Strictly for Teenagers, Some Facts about Venereal Disease.* Rev. 1964, illus. 5¢

4. *Syphilis, Modern Diagnosis and Management.* Rev. 1964, 63 p., illus. Cloth, $2.00; Paper $1.00.

5. *Veneral Disease Education.* Public Advisory Committee on Veneral Disease Control, 1964, 31p. 20¢

Films on Infectious Diseases

1. *Cleanliness Brings Health.* U.S. Office of Inter-American Affairs, 1945. Made by Walt Disney Productions. Re-released by U.S. Institute of Inter-American Affairs, 1946.

2. *How Disease Travels.* U.S. Office of Inter-American Affairs, 1945. Made by Walt Disney Productions. Re-released by U.S. Institute of Inter-American Affairs, 1946.

3. *What is Disease?* U.S. Office of Inter-American Affairs, 1945. Made by Walt Disney Productions. Re-released by U.S. Institute of Inter-American Affairs, 1946.

M. FIRST AID

Overall Objective:

To develop skill in administering first aid in selected circumstances.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To develop skills in meeting emergencies that require first aid.	1. *Course in first aid* a. Theories and skills (standard): (1) The why and how of first aid (2) Wounds (3) Shock (4) Artificial respiration (5) Poisoning by mouth (6) Injuries to bones, joints, and muscles (7) Burns and ill effects of heat and cold (8) Common emergencies (minor) (9) Transportation (10) First aid skills for standard course. b. Theories and skills (advanced): (1) The human body (2) Special wounds (3) Common emergencies (major) (4) Skeletal injuries (5) First aid kits and supplies (6) First aid skills for advanced course. c. Artificial respiration	1. Trainees to enroll in the First Aid Course conducted by the local chapter of the American Red Cross. If this is impossible, the trainer should make provision for covering the subject matter outlined at the left.
	2. *Immediate first aid measures that can be administered by aides*	2. Discuss the section on first aid as outlined in the trainee's manual, pages 77 to 80.

Suggested Film

This film can be obtained from the United States Government Printing Office, Washington, D. C.

1. *First Aid: Part 2. Everyday Emergencies.* (motion picture) U.S. Department of the Army.

N. INTERVIEWING SKILLS

Overall Objective:

To develop skill in interviewing while providing service to a patient.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To understand the concept of "confidentiality."	1. *Meaning of confidential information.* a. Interpreted differently by different agencies. b. Variations include: (1) Strictly classified – only certain key people in the organization have access to information. (2) Confidential within a program or subdivision of an agency – only selected employees of the subdivision have access to the information. (3) Confidential within agency – only persons within the agency have access to the information. (4) Confidential between agencies – agencies with agreements will exchange information. (This is generally the case with health and health-related agencies – in most cases patient/client must give written consent.) (5) Confidential among health and health-related workers. Example: for the benefit of the patient a private physician may divulge the diagnosis of the patient to a public health nurse. (6) Confidential in the respect that it is not accessible to the public, but is available to the individual. Example: police clearance. c. The health aide must treat all information that comes to him while performing his duties as confidential between himself and his trainer/supervisor. d. Careless divulging of information may seriously affect the relationship between the aide and the patient. In addition, it may reflect upon the integrity of the training program and the employing agency.	1. Discussion of trainees' experiences involving situations in which a professional or other person informs them that the information given was confidential. Discussion of experiences when the confidentiality of information given was violated. Discuss problems that may result from violating confidence. Group discussion of situations where the trainee was interviewed or interviewed someone else. Discuss feelings that are relative.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
2. To understand the three main types of communication.	2. *Types of communication.* a. Concepts: (1) The five senses (taste, touch, smell, hearing, sight) enable a person to communicate with the outside world. (2) Many factors interfere with effective communications. Some are: preoccupation, negative attitudes, prejudice, illness, language difficulty, and different cultures. b. Verbal communication: (1) Speaking and listening to what is being said. (2) Formal or informal. Health aide probably most comfortable with informal communication, and the atmosphere of an interview need not be formal. c. Nonverbal communcation: (1) People communicate all kinds of things to us by movements of muscles, attentiveness, lack of attentiveness, bodily posture, facial expression, hyperactivity, and various other physiological signs. (2) Nonverbal communication may sometimes be more important than verbal communication. (3) An awareness of the ways people communicate nonverbally is extremely important when caring for infants, children, ill persons, and elderly people. (4) Nonverbal communication is usually more difficult to interpret than verbal. (5) Verbal and nonverbal communication cannot be separated in real situations: they occur simultaneously. d. Written communication: (1) The written word makes a permanent record. (2) The written word does not allow for immediate clarification of unclear points as does verbal communication. (3) Often very helpful in confirming verbal communication. (4) A copy of the written communication should be retained by the health aide.	

OBJECTIVES	CONTENT	ACTIVITIES
3. To gain skill in effective interpersonal relationships.	3. *Interpersonal relationships.* a. All interpersonal relationships involve interaction between people. b. Before attempting to understand others, the health aide must understand himself: (1) Certain attitudes develop as a result of the personal experiences during a lifetime. (2) His own attitudes, feelings and prejudices must be recognized by the health aide. (3) The health aide may not rid himself of all negative attitudes, but if he knows what they are and what forms they take in his relationship to others, he will be better able to control them. (4) Some of the attitudes will be of great help in working with others; others will be hindrances; the skill lies in recognizing and utilizing the positive ones. c. There are two extremes in interpersonal relations, 1) impersonal and unimportant, and 2) very personal and quite important. (1) The success of the health aide will depend greatly upon how he conducts himself in relationships with co-workers and patients.	3. A frank discussion positive and negat attitudes. Health a trainer should s port the positive titudes and point c ways in which tl are beneficial working with tients.
4. To gain an appreciation of the importance of understanding others.	4. *Understanding others.* a. People are different. Each person comes with his own set of values, strengths, weaknesses, attitudes, etc. b. Learn to recognize emotional needs of others. These sometimes are far more important than physical needs. c. Be interested in the "whole" person, not just what you are concerned about. Ex.: If mother is worried about financial problems, listen to them, don't interrupt to discuss health needs. d. Personality differs with each individual. Personality is determined by hereditary traits and the life experiences of an individual. Personality develops very early in life. e. Differences in personality often relate to differences in perception (one's awareness of the outside world). No two persons perceive the same thing in the same way. Be aware that the best of intentions may not be interpreted that way by others. Do not be defensive. Attempt to understand why the	

OBJECTIVES	CONTENT	ACTIVITIES
	person responds as he does. From there, work toward a positive goal. f. Preconceived ideas. Example: All persons with religious beliefs different from one's own are not to be trusted. Preconceived ideas are a product of one's experiences and one's environment. g. Many ill patients experience great fear. Attempt to recognize this in others. Be aware of a patient's fear in all areas of your work.	
5. To appreciate the person's worth.	5. *Respect for person's worth.* a. Each human being has human dignity. b. Respect is an essential element of good interpersonal relationships. c. One must respect self in order to respect others. d. Every person has the right to be respected by health aide providing care. e. The health aide is a guest in the patient's home and should act accordingly.	
6. To develop skill in establishing rapport.	6. *Suggestions for establishing rapport.* a. Introduce yourself and state purpose of the visit. b. Express a desire to assist with health problems and other problems the person may be having. c. Observe for signs of acceptance or rejection. If rejection, attempt to discover reasons; if patient is receptive following your continued interest in him, pursue the interview. d. Informal conversation prior to interview helps to put the patient at ease. e. Show interest in patient's problems as he sees them.	6. Practice on co-workers. Have candid discussion about faults and assets. Health aide is to be encouraged to discover his own weaknesses.
7. To develop skill in effective interviewing.	7. *Useful hints on interviewing.* a. Make sure you feel relaxed and at ease prior to interviewing others. b. Encourage the patient to talk freely. c. Be a good listener. d. Determine the pace of the person being interviewed (how fast can the person go?). Once the pace is determined, adjust speed accordingly. e. Observe for nonverbal communication.	

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OBJECTIVES	*CONTENT*	*ACTIVITIES*
	f. Be aware of patient's fatigue.	
	g. Prior to beginning the interview, stress confidential nature of information to be obtained.	
	h. Make sure the patient is comfortable. Privacy may or may not be required.	
	i. Encourage a relaxed, informal atmosphere.	
	j. If recording is to be done, jot down notes and complete report following the conclusion of the interview.	
	k. Prepare for interview – obtain knowledge available about the person prior to the interview.	
	l. Explain purpose of interview to patient.	
	m. Be yourself; do not put on. Pretenses tend to disrupt the interviewing process.	
	n. Place sensitive questions near the end of the interview when possible.	
	o. Thank the person for his time at the end of the interview.	

References on Interviewing

1. Garrett, Annette, *Interviewing: Its Principles and Methods.* New York Family Service Association of America, 1942.
2. Burton, Geneviene, *Personal, Impersonal and Interpersonal Relations.* New York: Springer Publishing Company, 1958.
3. Ginsberg, Ethel L., *Public Health is People.* The Commonwealth Fund, 1950, p. 241.
4. Peplau, Hildegarde, *Interpersonal Relations in Nursing.* New York: G.B. Putnam's Sons, 1952.
5. Standard, Samuel and Nathan, Helmuth, *Should the Patient Know the Truth?* New York: Springer Publishing Company.
6. Fenalson, Anne F., *Essentials in Interviewing.* New York: Harper and Brothers, 1952.
7. Wolff, Ilse S., "Interviewing in Public Health Nursing: An Examination of Attitudes," *Nursing Outlook,* VI. No. 5, May, 1958, pp. 207-69.

O. RECORDING SKILLS

Overall Objective:

To develop skill in recording on the health record.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To understand the importance of record keeping.	1. *Importance of record keeping* a. First interview provides information which is used in measuring later improvement of patient. b. The health aide records health needs and problems as first step in developing care plan. c. Provides data for types of persons served and services rendered that may be used for program evaluation purposes. d. Useful for planning subsequent visits.	1. Instruct trainees to complete history section of record forms of employing health agency, using their own families as examples. Recording skills to be further developed during on-the-job training. Periodic review of recording skills during training period.
2. To understand the confidential nature of record information.	2. *Confidential nature of records* a. The policy of the training program and employing agency will dictate the degree of confidentiality that will apply to information contained in the record. b. All health agencies have an established policy regarding the confidential nature of record information. c. The most frequent practice is to obtain the written consent of the patient prior to releasing medical information. Standard permission forms are usually available for this purpose.	2. Review own agency's policy concerning confidentiality.
3. To understand the content of a health record.	3. *Typical content of health record* a. Fact sheet. (1) Identifying information – family roster: (a) Names and sexes of family members (b) Address (c) Birthdates (d) Race (e) Telephone number	

(f) Private doctor's name, address, telephone – if applicable

(g) School attended.

b. Family history.

(1) Health problems.

(2) Dates health care received.

(3) Social problems.

(4) Type and date of social services received.

(5) Employer.

(6) Source and level of income.

c. Narrative notes.

(1) Date of contact of health aide.

(2) Time of contact.

(3) Running chronological account of home visits, phone calls, and office contacts.

(4) Signature of aide providing care.

(5) Running account should include:

(a) Purpose of contact

(b) Persons contacted

(c) Problems encountered

(d) Type of service rendered

(e) Plan for subsequent visit.

d. Health care plan.

(1) Component part of record.

(2) States problems, needs, plan for action and evaluation of actions taken.

(3) Guideline for rendering care to patient.

(4) Continuous revision based on analysis of needs and problems.

OBJECTIVES	CONTENT
4. To develop skill in recording on a health record.	4. *Useful hints for recording on health record*

a. The health aide should provide sufficient information in all areas of the health record to allow another person to gain an accurate impression of the family's health problems, needs, and care rendered.

OBJECTIVES	CONTENT	ACTIVITIES
	b. Neatness in recording is a must. Serious consequences may result from recording errors. c. Proficiency in spelling is highly desirable. d. Ability to use common medical terminology.	4c. Effort should be made by trainees to improve spelling abilities. Where serious spelling deficiencies exist, emphasis should be placed on basic words during remediation classes.
	COMMON MEDICAL TERMINOLOGY This list* will serve as a guide to the health aide in determining the meaning of medical terms. The material is presented as a list of prefixes and suffixes derived from the ancient Greek and Latin languages. Each prefix and suffix is defined and followed by a medical term and its meaning.	Encourage the trainees to provide additional medical terms using the same prefixes and suffixes.

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*The list described can be found on p. 88 of the trainee manual.

P. EVALUATION

Overall Objective:

To gain an understanding of how to measure the success of the training and the performance of the individual.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
	Suggested standards for evaluating Community/Home Health Aides appear, along with sample evaluation forms, in the trainee manual.	Refer to trainee manual, p. 101, for material described at left. Trainees are to complete sample evaluation forms using the standards discussed. The trainer may wish to duplicate the health aide evaluation form which appears in the trainee manual for use in evaluating the trainees.

References on Evaluation

1. Freeman, Ruth B., *Public Health Nursing Practice,* Philadelphia, W. B. Saunders Co., 1957.
2. Heller, Barbara S., Sarp, Laure, M. "Evaluation of the Neighborhood Health Aide Project, A Report Prepared for the D.C. Department of Public Health and the Health and Welfare Council of the District of Columbia," Washington, D.C., Bureau of Social Science Research Inc., November, 1966.
3. Levine, M.D., Reid, I.D. and Hurst, B. *Techniques for the Evaluation of Training Programs,* Institute for Youth Studies, Howard University, Washington, D. C., 1966.
4. Shetland, Margaret, "A Dynamic Approach to Evaluation," *Nursing Outlooks,* V. No. 12, December, 1956, 711-713.

CHAPTER V

THE HOME HEALTH AIDE SPECIALTY CURRICULUM

A. THE PATIENT

Overall Objective:

To gain an understanding of the patient and the effects of illness upon the individual.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To gain an understanding of the definition of a patient.	1. *Definition of a patient.* a. A patient is a person in need of health care. The care may be preventive, curative, restorative, and/or rehabilitative in nature. b. A patient is a human being, and being so has human dignity which distinguishes him from lower animals.	1. General discussion. The health aides should participate as much as possible in the discussion in order to gain an appreciation of the comprehensive meaning of *patient.* Personal examples of the content covered should be brought out by discussing observations during field visits to therapeutic and preventive care facilities.
2. To gain insight into the psychological aspects of an illness.	2. *Illness.* a. An illness interrupts the equilibrium of a person physically, as well as emotionally and psychologically. b. Personality changes often result from illness. c. The ill person may feel inadequate in several ways. (1) No longer able to assume head of household responsibilities. (2) Loss of sexual drive. (3) Assumes role of dependent person. (4) Doubts regarding self worth. d. Anxiety induced by illness and the "sick role." e. Worries about family, job, finances, etc.	
3. To gain an understanding of the relationship of the patient to other family members.	3. *The patient is an integral part of the family.* a. The function previously assumed by the ill person may cease, be taken over by another family member, or may be only partially assumed by the patient. b. The patient may support other family members during his illness or he may be a destructive force. c. The family may be understanding and/or supportive of the patient or it may be a negative factor.	3. Discuss key concepts in bi-weekly seminars.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
4. To gain an understanding of the concept of patient-centered care.	4. *Patient-centered care.* a. All of the care given is directed toward improving or maintaining the health condition of the patient. b. The person giving care must consider the physical, social, emotional, and spiritual needs of patient. c. The welfare of the patient must be the major concern of the person providing care.	

References on the Patient

1. Brown, Lucille Ester, *New Dimensions of Patient Care Part I.* New York, Russell Sage Foundation, 1961.
2. Brown, Lucille Ester, *New Dimensions of Patient Care Part II.* Russell Sage Foundation, 1962.
3. Woodworth, R.S., *Dynamics of Behavior.* New York, Henry Holt and Company, 1958.
4. Burton, Genevieve, *Personal, Impersonal and Interpersonal Relations.* New York, Springer Publishing Company, 1958.
5. Lederer, H. D., "How the Sick View Their World," *Journal of Social Issues,* 1952. 8 pp.
6. Field, Minna, *Patients Are People, A Medical-Social Approach to Prolonged Illness.* 2nd ed. Columbia University Press, New York, 1958, pp. 199-201.
7. Menimoto, Francoise, R. and Greenblatt, Milton, "Personal Awareness of Patient's Socializing Capacity," *American Journal of Psychiatry* Vol. 110 December 1963, pp. 443-447.
8. Willie, Charles V., "The Social Class of Patients that Public Health Nurses Prefer to Serve," *The American Journal of Public Health* Vol. 501 August, 1960, pp. 1126-1136.
9. Towle, Charlotte, *Common Human Needs.* New York, National Association of Social Workers, 1957.

B. TOTAL CARE PLAN AND HOME HEALTH AIDE CARE PLAN

Overall Objective:

To gain an understanding of the plan of care for an individual patient.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
To gain an understanding of the rationale of the total care plan.	1. *The purpose of a total care plan.* a. Providing a written guide for appraising the health needs of an individual patient. b. Developing acceptable goals. c. Providing an estimate of the resources within the family and the community for meeting needs. d. Developing mutually agreed upon plan of action. e. Establishing methods of evaluating the results of the plan. 2. *Development of total care plan.* a. Statement of diagnosis. (1) Physician provides diagnosis. (2) Primary and secondary diagnosis. (3) The diagnosis will determine to a certain extent the type of care the patient needs. The medication and other forms of treatment in particular will be closely related to the diagnosis. Example: diabetes–diet, insulin, and frequent urine checks. b. Statement of needs. Hypothetical situation – diabetic patient, 48 years old (has been diabetic for 10 years), is receiving 10 units of insulin daily, has 2500 calorie diet and limited exercise, because she is bedridden 3 out of 7 days a week. Has corns on feet and severe varicose veins in legs. (1) Prescribed needs (doctor's orders). (a) Daily medicine. (b) Special foot care. (c) Diabetic diet–2500 calories divided into four meals. (d) No massage of legs.	1. General discussion. Health aide trainer will allow free discussion. Examples of total care plan will be shown. During the on-the-job training a health aide care plan will be developed and used for every patient.

        (e) Walk three times around the room per day.

    (2) Nursing care needs.

        (a) Personal hygiene.

        (b) Health teaching.

        (c) Diversionary activity.

        (d) Exercise.

c Plan of care.

    (1) Give insulin at 8 a.m. daily.

    (2) Special foot care, including bathing feet, monthly trips to podiatrist for nail trimming, and care of corns.

    (3) Daily bedbath, occasional shower when condition permits. Handrails provided in shower, sit on chair in shower.

    (4) Daily change of linen.

    (5) Frequent positioning in bed.

    (6) Health teaching.

        (a) Diet instruction to other members of the family – shopping, preparation, and types and amounts of food. Diabetic exchange lists.

        (b) Cause of diabetes, precautions to be taken, prevention of complications, need for following orders.

    (7) Provision of recreational therapy equipment, consultation with recreational therapist.

    (8) Ambulation using walker when indicated.

    (9) Periodic conferences with team (M.D., P.H.N., health aide, therapist, nutritionist, social worker).

d. Evaluation.

    (1) To what extent has care met stated needs?

    (2) Need for change in plan depending upon improvement or regression of patient.

    (3) Estimate of condition of patient every 2 weeks, or more often when necessary.

OBJECTIVES	CONTENT	ACTIVITIES
3. To understand the team approach.	3. *Team approach in meeting the patient's needs.* a. The team consists of the physician-leader, nurse, therapist, health aide, social worker, and any other person providing care to the patient. b. Each member of the team is assigned a specific function. c. All members of the team must function effectively in order to provide patient-centered care. d. The team meets periodically to plan for the care of the patient.	3. Review earlier discussion in unit on public health administration. Have trainees cite observed examples where team approach was used effectively and where it might have been used and was not.
4. To understand the role of the team member.	4. *The role of each member of the team.* a. Physician – provides leadership, diagnosis, prescribes orders, provides medical care. b. Nurse – usually coordinates the team, provides supervision for health service aides on team, provides nursing care. c. Therapist – (recreational, physical, and occupational) – provides plans for specialty. Also provides care as part of the overall plan of care. d. Health aide–works under supervision, provides bedside care, exercises, prepares meals, cleans sick room, and gives health instruction to the patient. e. Social worker – provides leadership in dealing with all social problems, makes referral to appropriate social agencies.	
5. To gain understanding of the implementation of the total care plan.	5. *Implementation of the total care plan.* a. Members are assigned duties. b. Health aide performs duties initially under close supervision; after skills are developed, the health aide performs the duties without direct supervision. Periodically the supervisor is informed of the progress of the patient. All urgent problems are to be brought to the immediate attention of the supervisor. c. All members of the team work in a coordinated fashion.	
6. To understand the evaluation of a care plan.	6. *Evaluation.* a. This is a joint venture of all team members. b. Each member provides a brief oral or written summary of the needs in his area and the care provided.	

OBJECTIVES	CONTENT	ACTIVITIES
	c. Following the presentation, the team decides whether or not the needs have been met, whether to redesign the plan, and any other alterations necessary to accomplish the stated objectives.	
7. To understand skill in establishing and implementing a Home Health Aide care plan.	7. *Home Health Aide care plan.* a. Definition – the overall guide for providing bedside and related care to an individual patient; the care to be provided by the health aide to the patient as assigned by the supervisor. b. Procedure – under close supervision, outline the: (1) Needs (2) Goals (3) Plans for implementation (4) Evaluation (5) Alteration in plan. c. The Home Health Aide care plan is a more detailed plan than the total care plan, and it constitutes a part of the whole. The Home Health Aide will develop a care plan for each assigned patient during the on-the-job training experience.	7. Refer to trainee manual, p. 116, for a sample Home Health Aide care plan. Be sure that trainees understand the components of a complete plan, and work with them in the development of similar plans for the patients in their charge.

References on the Total Care Plan and Home Health Aide Care Plan

1. U.S. Public Health Service, *Elements of Progressive Patient Care,* Washington, February 27, 1959.
2. Abdellah, Faye G. and Strachan, E. Josephine,"Progressive Patient Care," *American Journal of Nursing,* Vol. 59. May, 1959. pp. 649-655.
3. Stieger, William A., Hoffman, Francis H., Hansen, Victor and Niebuhr, H. "A Definition of Comprehensive Medicine," *Journal of Health and Human Behavior,* Vol. 1, Summer, 1960. pp. 83-86.
4. Freeman, Ruth B., *Public Health Nursing Practice,* Philadelphia, W. B. Saunders Co., 1957
5. *Patients, Physicians and Illness,* edited by E. Gartly Jaco. The Free Press, Glencoe, Ill. 1958.
6. "Let's Take a Good Look at the Aging," *American Journal of Nursing,* March, 1961.
7. Rogers, Carl R., *Client-Centered Therapy,* New York, Houghton Mifflin Company. 1951.
8. Unpublished Materials, District of Columbia Department of Public Health, Division of Chronic Diseases Control, Home Care Program.
9. Harte, M. A. and Hughes, B., "Understanding Within the Public Health Nursing Team," *Nursing Times LIV* (January 24) 1958. pp. 96-98.

C. BEDSIDE CARE

Overall Objective:

To develop proficiency in providing selected bedside care measures to ambulatory and bedridden patients according to specific patient needs.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
	The trainer is referred to the trainee manual, p. 177, for the material to be covered on bedside care.	

Films and Filmstrips on Bedside Care

All material listed can be obtained from the U.S. Government Printing Office, Washington, D. C.

I. Care of Bedridden and Ambulatory Patient

1. *Basic Care of Patients. Part 1: Cleaning the Patient's Unit and Making an Unoccupied Bed.* (motion picture) U.S. Department of the Army, 1957.
2. *Basic Care of Patients. Part 2: The Bed Bath.* (motion picture) U.S. Dept. of the Army, 1957.
3. *Basic Care of Patients. Part 3: Making an Occupied Bed.* (motion picture) U.S. Dept. of the Army, 1957.
4. *Basic Care of Patients. Part 5: Feeding the Patient.* (motion picture) U.S. Dept. of the Army, 1957.
5. *Basic Care of Patients. Part 7: Sterile Technique.* (motion picture) U.S. Dept. of the Army.
6. *Bathing the Patient: Home Care.* (filmstrip) U.S. Office of Education in cooperation with the U.S. Public Health Service, 1945. Made by Ted Nemeth Studios.
7. *Bathing the Patient: Home Care.* (motion picture) U.S. Office of Education in cooperation with the U.S. Public Health Service, 1945. Made by Ted Nemeth Studios.
8. *Feeding the Patient.* (motion picture) U.S. Office of Education with cooperation of U.S. Public Health Service, 1944. Made by Willard Pictures.
9. *The Vital Signs and Their Interrelation: Body Temperature, Pulse, Respiration, Blood Pressure.* (motion picture and filmstrip) U.S. Office of Education in cooperation with the U.S. Public Health Service, 1945. Made by Willard Pictures.

II. Infant Care

1. *Care of the Newborn Baby: The Nurse's Role in Instructing the Parents.* (motion picture and filmstrip) U.S. Office of Education with cooperation of U.S. Public Health Service, 1944. Made by John O. Haeseler.
2. *Infant Care.* (motion picture) U.S. Office of Inter-American Affairs. 1945. Made by Walt Disney Productions. Re-released by U.S. Institute of Inter-American Affairs, 1946.
3. *Wise Parents, Healthy Babies.* (motion picture) U.S. Institute of American Affairs, 1947. Made by Apex Film Corp.

III. Care of the Patient with Selected Chronic Diseases and Conditions

1. *Care of Cardiac Patient.* (motion picture and filmstrips) U.S. Office of Education with the cooperation of U.S. Public Health Service, 1945. Made by Willard Pictures.

2. *Care of the Patient with Diabetes Mellitus: Uncomplicated.* (motion picture and filmstrip) U.S. Office of Education with the cooperation of U.S. Public Health Service, 1945. Made by Willard Pictures.

3. *Therapeutic Use of Heat and Cold. Part 1: Administering Hot Applications.* (motion picture and filmstrip) U. S. Office of Education with the cooperation of U.S. Public Health Service, 1945. Made by Willard Pictures.

Pamphlets on Care of the Sick

These pamphlets may be obtained in quantity and given to trainees.

1. *Home Care of the Sick.* Reprinted 1960. 6 p. 5¢

2. *Up and Around.* A booklet to aid patient in activities of daily living. 1964. 37 p. illus. 50¢

Additional Films on Bedside Care

All films listed below are available from: EEGE Associates, 4715 Kingsessing Avenue, Philadelphia, Pennsylvania 19143

1. *To Care Enough.* The place of the nursing aide on the health care team; what her attitude and appearance should be; the nursing aide's duties, associations and rewards for service; maintaining patient privacy and dignity; staff and patient relationships; responsibilities in various health care centers.

2. *The Bed and Bedside Unit.* The uniform; prevention of bedsores; importance of a properly made bed; how to make an unoccupied bed; how to make an occupied bed; using bed controls, positioning patients for comfort; maintenance and sanitation of the bed and bedside unit; safety precautions; observing the patient; how to report these observations; the nursing aide's outlook and attitudes.

3. *Bathing the Patient.* Importance of cleanliness and bathing; giving morning care; encouraging patient independence and self-help; assisting patient with tub and shower bath; giving a bed bath, back rub and massage; recording information on patient's record; need for scalp, hair and nail care; how to give shampoo at sink or in bed; importance of patient grooming; the nursing aide's appearance; how to receive orders from charge nurse.

4. *Meeting the Patient's Excretory Needs.* Improving memory; description of excretion; assisting ambulatory patient with toilet needs; assisting with bedpan and urinal; cleaning and maintaining equipment used; intake and output; collecting urine and stool specimens; labeling; description of enemas and how they are administered; caring for incontinent patients; assisting with urinary catheter drainage.

5. *Patient Feeding and Mouth Care.* Importance of punctuality; A.M. mouth care; the handling and care of dentures; mouth care for a helpless patient; importance of nutrition; assisting a patient in feeding himself; feeding a patient who needs complete help; assisting a blind patient with eating; food intake and output.

6. *Temperature, Pulse and Respiration.* The need for accuracy; importance of proper observation and recording; temperature; the thermometer, how it works and how to read it; care of thermometer; how to take oral, rectal and axillary temperature; how to record the temperature; the pulse, description and significance; how to take and record the pulse; where to take the pulse; how to distinguish the quality of the pulse; how to count respirations and distinguish the quality; how to record the respirations; importance of the need to observe professional ethics.

D. RANGE OF MOTION EXERCISES

Overall Objective:

To gain skill in conducting range of motion exercises on ambulatory and bedridden patients.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To understand the physiology and anatomy involved in movement of various parts of the body.	1. *Ambulatory and bedridden patient* a. Joint movements: (1) Active or passive (2) Stimulates circulation (3) Restores function (4) Preserves function (5) To be given per specific order of physician. b. Types of movements: (1) Flexion – leg, arm bending (2) Extension – straighten leg or arm (3) Adduction – move arm toward body (4) Abduction – move arm away from body (5) Circumduction – bend around, hand (6) Rotation – turn around, knee joint (7) Pronation – turn downward, hand (8) Supination – turn upward, hand.	1. At the time the health aides are being taught this unit each is to be assigned a patient that requires range of motion exercises as part of the on-the-job training experience. The parts of the skeletal and muscular system are to be named when movement relates to the part in each individual. Refer to p. 63 for a diagram of the skeleton and to the trainee manual, p. 135, for a diagram of the muscles of the human body. Trainees are to practice on one another. When on the job, they are to perform exercises after being instructed by physical therapist and/or nurse. The trainee is to perform the demonstration before continuing without observation from a professional.
	2. *Range of motion exercises to be practiced and learned*	2. The trainer is referred to the trainee manual, p. 136, for step-by-step illustrations of the exercises, and to p.173 and 174 for information on the evaluation of the effectiveness of exercises and the procedure to be followed in changing the exercise regimen.

E. HOUSEKEEPING PRACTICES

Overall Objective:

To develop skill in maintaining a therapeutic physical environment in the sickroom.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
To gain insight into the principles of maintaining a therapeutic and preventive milieu.	The principles and skills necessary in the performance of household duties are presented in the trainee manual.	A general discussion on the subject of good housekeeping principles, during which the trainees will be encouraged to contribute principles in addition to those listed which they feel are important. The trainer is referred to the trainee manual, p. 175, for the material to be presented.

F. CARE OF THE INFANT

Overall Objective:

To gain skill in providing selected aspects of infant care.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
To acquire knowledge and skills needed in the care of the infant.	The material to be presented in this unit will be found in the trainee manual.	The trainer is referred to the trainee manual, p.177, for the material to be presented in this unit. The trainer will demonstrate the procedures outlined, using a baby doll and any other necessary props. In turn, each trainee will be required to perform the procedure. During the on-the-job training, the trainees will demonstrate procedures, giving baths, etc. in the homes they visit.

References on Maternal and Child Health

1. American Academy of Pediatrics: *Child Health Services and Pediatric Education.* The Commonwealth Fund, New York, 1949.
2. Schlesinger, E. R.: *Health Services for the Child.* McGraw-Hill., Inc. New York, 1963.
3. World Health Organization: *Administration of Maternal and Child Health Services.* WHO Technical Report Series, No. 115, Geneva, 1957.

CHAPTER VI

THE COMMUNITY HEALTH AIDE SPECIALTY CURRICULUM

A. THE FAMILY

Overall Objective:

To gain an understanding of the family and some of its ramifications.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To gain an understanding of the family.	1. *Definition of the family.* a. Primary family consists of the mother, father, and the offspring. b. Extended family consists of the mother, father, offspring, and other relatives – grandmother, uncles, cousins, etc. c. Matriarchal – family affairs governed by female head of household. d. Patriarchal – family governed by male head of household. 2. *Some of the characteristics of the family today:* a. Individualism b. More children since World War II c. More unstable than before–divorce rate increasing d. Traditional functions declining–religion, education e. More activity outside of the home than before f. Many mothers work g. Disrupted families – one parent family h. More urbanization i. Less cohesiveness among members j. Older members of the family live in nursing homes, alone, etc. k. Illegitimate children l. Economic dependence upon institutions. 3. *Functions of the family.* a. Care and protection of the children. b. Education of the children. c. Social control over its members.	1. The trainees are to relate the discussion of the family while in the classroom to the families for whom they provide care during the OJT experiences.

OBJECTIVES	CONTENT	ACTIVITIES
	d. Economic element. e. Procreation of children.	
4. To gain an understanding of the relationship of the patient to other family members.	4. *The patient is an integral part of the family.* a. When a family member becomes ill, he may not be able to continue fully to perform his role in the family. This role may be assumed partially or completely by another family member. b. The patient may support other family members during his illness, or he may be a destructive force. c. The family may be understanding and/or support the patient, or it may be a negative factor. d. The patient may become isolated from the other family members or the patient may tend to be a cohesive factor – bringing previously loosely related family members to a point where group feeling arises as a result of a common concern.	
5. To gain an understanding of the concept of patient-centered care.	5. *Patient-centered care.* a. All of the care given is directed toward improving or maintaining the health condition of the patient. b. The person giving care must consider the physical, social, emotional, and spiritual needs of patient. c. The welfare of the patient must be the major concern of the person providing care.	

Suggested References on the Family

1. Sirjamaki, John, *The American Family in the 20th Century.* Cambridge: Harvard University Press, 1953, pp. 38-42. Copyright 1953 by the President and Fellows of Harvard College.

2. Greedman, Ronald, Whelpton, Pascal K., and Campbell, Arthur A., *Family Planning, Sterility, and Population Growth.* New York: McGraw-Hill, 1959.

3. Miller, Daniel R., and Swanson, Guy E., *The Changing American Parent.* New York: Wiley, 1958.

4. "Health and the Changing American Family." *Progress in Health Services,* VII, September, 1958. pp. 1-2.

5. "Family Spending Pattern and Health Care." *Progress in Health Services,* January, 1960.

6. Freeman, Ruth B., "Impact of Public Health on Society." *Public Health Reports,* 76, April, 1961.

7. Hiller, E.T., *Social Relations.* New York: Harper and Brothers,1947.

8. Rogolf, Natalie, *Recent Trends in Occupational Mobility.* Glencoe: The Free Press, 1953.

9. Saunders, Lyle, *Cultural Differences and Medical Care.* New York: Russel Sage Foundation.

10. Warner, W. L. and others, *Social Class in America.* Chicago: Science Research Associates, 1949.

B. FAMILY HEALTH NEEDS

Overall Objective:

To develop skill in assessing health needs of the entire family and to implement the family care plan.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To understand the definition and concept of family health needs.	1. *Definition – family health needs encompass the physical, mental, psychological and social elements that contribute to the well-being of the family.* 2. *Concepts* a. Family health needs are influenced by four major factors. (1) The health situation itself. (2) The environment in which the family lives. (3) The social-cultural milieu. (4) Patterns of behavior that are characteristic of the members of the family. 3. *Assessment of family health needs* a. The health situation: (1) Nature of the disease or health problem that confronts family or a member of the family. Example: a patient with a heart condition requires adequate rest, special diet, regulated activity, and in some instances, special medicine. (2) A physiological state may also produce specific health needs in absence of a disease. Example: a pregnant patient will need adequate calcium and protein intake, postural adjustment, special clothing, and regular physical checkups. (3) Age may be the determinant of health needs; each age group has its major hazards to life and health. Example: newborn infant is particularly susceptible to infection, changes in food, and water imbalance; the school-age child is particularly susceptible to accidents; the person in middle years has needs associated with the higher incidence of chronic diseases among that group; the elderly person is susceptible to accidents and is more likely to be malnourished.	1. The trainer will direct group discussion of the concepts of the family health needs. The health aides will develop a family care plan for their own families. While experiencing on-the-job training, the health aides will develop family care plans for each family in their case load.

(4) Sex may be a determinant of certain health needs. Example: females require higher intake of iron once the age of puberty is reached. Adult males are more susceptible to heart attacks. Certain diseases occur among males only—color blindness, hemophilia.

b. The environment:

(1) Weather extremes, heavy street traffic, presence of wildlife, presence of harmful insects, prevalence of certain diseases can all be environmental determinants of health needs.

(2) The health needs arise from the dangers inherent in both home and working situations.

(3) The rural community may present problems arising from unsafe water supply, sewage disposal, and the dangers of infections due to bacteria that thrive in farm environments. Urban inhabitants must be alert to frequent automobile accidents, unsafe play areas. The suburban community may have problems of garbage disposal, water supply, and sewage disposal.

c. The social-cultural setting:

(1) Low income neighborhoods may show evidence of a higher crime and accident rate than other parts of the community. Such a high risk environment may give rise to a general disregard for routine health maintenance.

(2) Because health services in lower income areas have often proved inadequate to meet the demand in an efficient manner, the residents of the community may show a negative attitude toward seeking health care, based on previous experience with long waits and lack of individual attention to their needs. Overcoming this attitude with individual attention and support is one of the most important functions of the health aide.

(3) The dietary habits of some ethnic and regional groups may result in a lack of certain nutritional necessities.

(4) Overcrowded housing, inadequate education, and other indices of poverty are associated with high rates of venereal diseases, tuberculosis, illegitimate pregnancies, and some mental illnesses.

(5) Some cultural groups, because of long-established habits and a lack of health education, may make use of various home remedies

OBJECTIVES	*CONTENT*	*ACTIVITIES*
	and "old wives' tales" when dealing with a disease or other types of health problems.	
	d. Characteristics of the individual family: (1) Income, physical equipment, competence in utilizing resources (2) Family cohesiveness and emotional security (3) Established patterns of health behavior and attitude toward health care.	
4. To gain an understanding of the family care plan.	4. *Definition and concepts of a family care plan*	
	a. The family care plan is the written guide that states health needs, goals, plan of action, and evaluation for all members of the family.	
	b. Each family member has his own peculiar health needs which arise from age, sex, state of health, and other individual qualities.	
	c. The family care plan is not a static document; it is a dynamic plan that changes as the needs of the family members change.	
	d. The family care plan developed by the health aide should contain those action plans that are within the scope of the health aide's functions and are assigned by the supervisor.	
	e. The health aide should keep in mind that a plan is only as good as the ability of the aide and family to implement it.	
5. To gain skill in developing a family care plan.	5. *Implementation of a family care plan*	
	a. Statement of health needs, both by health aide and family. Quite often the acceptance of health needs by the family comes much later. The acceptance of health needs by the family is a long range goal; in the meantime, the health aide records all perceived health needs.	
	b. Once the needs have been established, goals are developed: (1) Goals should be simply stated in terms of what it is hoped will be accomplished. (2) The goals should be stated in such a way that they can be tested. (3) Short-term and long-term goals should be outlined.	

OBJECTIVES	CONTENT	ACTIVITIES
	c. Following the statement of goals, plans for action are developed: (1) Areas for immediate action are stated; then long-range plans are stated. (2) Sometimes the short-range goals and plans are very obvious. Example: a pregnant mother needs a complete physical examination to determine cause of prolonged upset stomach. (3) Plans for action are usually developed step-by-step according to the resources available within the community and the family and the availability of the health aide and other health workers. (4) Prior to implementation of the plan, the family must accept the needs and goals described in the plan.	
6. To gain skill in evaluating the action taken relative to the family care plan.	6. *Evaluating the action of the family care plan* a. To what extent have the stated goals been accomplished? b. Throughout the contact between the health aide and the family, the accomplishment of goals should be evaluated and re-evaluated. c. The evaluation should take into account the measure of success as seen by the health aide and by the family.	6. The trainees evaluate the family care plan results for families to whom they have provided service.

References on Family Health Needs

1. Freeman, Ruth, B., *Public Health Nursing Practice.* W. B. Saunders Co., Philadelphia, 1957.
2. Mustard, Harry S. and Stebbins, Ernest, L., *An Introduction to Public Health.* Macmillan Co., New York, 1959.
3. Towle, Charlotte, *Common Human Needs.* New York: National Association of Social Workers.
4. "Health and the Changing American Family," *Progress in Health Services* VII, September, 1958.
5. "Family Spending Pattern and Health Care," *Progress in Health Services*, January, 1960.
6. National League for Nursing. *Family Centered Public Health Nursing.* League Exchange No. 39. New York: National League for Nursing, 1959.

C. SELECTED COMMUNITY HEALTH PROBLEMS AND NEEDS

Overall Objective:

To acquire information regarding health problems and needs on the national level in order to comprehend better local health problems and needs.

OBJECTIVES

1. To acquire information regarding maternal health needs.

CONTENT

1. *Maternal Health Information, Problems, and Needs.*

    a. This area is the foundation of all public health programs.

    b. Adverse influences during the prenatal, birth, and postnatal period can seriously reduce the personnel resources of a nation.

    c. Since 1945, maternal mortality has declined about 95% and infant mortality about 75%.

    d. There has been remarkable progress made in all areas of care relative to maternal and child health programs.

    e. There is a wide discrepancy between the maternal death rates for whites and nonwhites.

        (1) 1960: all maternal deaths, 3.7 per 10,000 live births.

        (2) 1960: nonwhite maternal deaths, 10.1 per 10,000 live births.

    f. There is wide disparity between maternal death rates for northern and southern states.

        (1) 1960: 8.6 maternal deaths per 10,000 live births in Mississippi.

        (2) 1960: 1.46 maternal deaths per 10,000 live births in Minnesota.

    g. While these rates tend to correlate race with maternal mortality, the true correlation is between poverty and maternal death rates.

        (1) The majority of maternal deaths occur when the patient delivers outside the hospital setting and is not attended by a trained physician.

        (2) It was found in Mississippi and South Carolina that the majority of the nonhospital and nonmedically attended deliveries were among the nonwhites.

ACTIVITIES

1. The trainees are to be encouraged to discuss the local health problems.

    Bring in recent newspaper clippings regarding health problems.

    The trainer should acquire health data that shows the magnitude of the local problem for purposes of comparison with national figures.

    Local health department representative to discuss local health problems and needs.

OBJECTIVES *CONTENT* *ACTIVITIES*

h. Maternal mortality is closely correlated to age.

    (1) 1960: 2.3 maternal deaths per 10,000 live births in women under 20 years of age.

    (2) 1960: 29.0 maternal deaths per 10,000 live births in women 45 years and older.

    (3) The maternal mortality rate is very high for the very young because of small pelvic bones, physical immaturity, and illegal abortions.

    (4) High rates among older women are most likely related to higher incidence of chronic disease.

i. Most maternal deaths occur very soon after an abortion or the delivery of a child.

j. Leading causes of maternal deaths, 1960:

    (1) Toxemias of pregnancy

    (2) Hemorrhage

    (3) Abortion with sepsis

    (4) Sepsis of pregnancy and childbirth

    (5) Ectopic pregnancy

    (6) Toxemia or sepsis resulting from abortion.

2. To understand infant and child health problems and needs.

2. *Infant and Child Health Information, Problems and Needs.*

a. The nation's loss of infants is approximately 110,000 per year in spite of medical progress. (Infant = 1 yr. and under.)

b. 1960: infant mortality rate 25.7 per 1,000 live births. (Is usually much higher than maternal death rate.)

c. There is a large difference between the death rate of white and nonwhite infants.

    (1) 1960: 22.9 white infant deaths per 1,000 live births.

    (2) 1960: 43.2 nonwhite infant deaths per 1,000 live births.

d. The geographic pattern of infant deaths is consistent with the pattern for maternal deaths.

e. Poverty and its many ramifications play an important role in the infant death rate.

f. Six leading causes of death for infants 28 days and under.

  (1) Immaturity

  (2) After-birth asphyxia

  (3) Birth injuries

  (4) Congenital malformations

  (5) Variety of diseases peculiar to infancy, including nutritional problems

  (6) Pneumonia

g. Ten leading causes of deaths of infants 1 year and under.

  (1) Diseases of early infancy (neonatal)

  (2) Congenital malformations

  (3) Influenza and pneumonia

  (4) Accidents

  (5) Gastroenteritis

  (6) Meningitis

  (7) Hernia and intestinal obstruction

  (8) Bronchitis

  (9) Heart disease

  (10) Malignant neoplasms

h. Premature infant deaths have declined substantially as a result of newer techniques.

i. The heart disease deaths during the infant stage are due primarily to congenital heart defects.

j. Preschool period (1-5 yrs.) is the most favorable in relation to risks of mortality.

  (1) From 1900 to 1960, the death rate among this age group declined from 20.0 to 1.1 per 1,000 live births.

k. The progress made in combating communicable diseases is largely responsible for the decrease in the death rate of the preschool group.

l. Comparison of 10 leading causes of death (preschool group):

1900	1960
Influenza and pneumonia	Accidents
Diarrhea and enteritis	Influenza and pneumonia
Diphtheria	Congenital malformations
Tuberculosis	Malignant neoplasms
Measles	Gastritis
Accidents	Meningitis
Scarlet fever	Bronchitis
Whooping cough	Meningococcal infections
Dysentery	Heart disease
Nephritis	Measles

m. With its low death rate, the preschool period is accompanied by a high morbidity rate.

  (1) Recovery rate is high.

  (2) Duration of illness brief.

n. Problems relating to mental-emotional development are the greatest cause of mental illness. The preschool period can often determine a positive or negative course in adulthood.

o. The school-age child (5 to 14 yrs. of age). Similar to the preschoolers, mortality rates are low and morbidity rates are high.

p. Five leading causes of death among the school-age children in 1960:

  (1) Accidents

  (2) Malignant neoplasms

  (3) Congenital neoplasms

  (4) Influenza and pneumonia

  (5) Heart disease.

q. Maternal and child health needs.

  (1) Begin prior to conception of child.

OBJECTIVES	CONTENT	ACTIVITIES
	(2) Depend on the nature and scope of the problems. (3) Early prenatal care. (4) Health education in all areas. (5) Adequate nutrition. (6) Adequate health facility and trained staff. (7) High quality care made available to all segments of the population. (8) Adequate well child and school health programs. (9) Improved methods of casefinding. (10) Health programs designed to deal with local community problems.	
3. To gain knowledge of environmental health concepts, problems and needs.	3. *Environmental Health.* a. Environmental health problems affect persons of all income levels, races, and religious beliefs. b. Environmental health differs from neighborhood to neighborhood, state to state, and nation to nation. c. Most of the public health laws relate to environmental health problems. d. Originally, environmental health measures were geared to preventing contamination of food and water in local communities. e. More recently, environmental health efforts have been directed toward control of contamination in larger areas. f. There is a close correlation between poverty, high incidence of disease, and poor environmental conditions. g. There are many communities that have no public waterworks systems and still more with inadequate facilities. h. In rural areas, each resident is often solely responsible for the disposal of his own refuse and the maintenance of his surroundings. i. As a result, low standards of environmental health may prevail in rural areas. It is necessary that the state extend its public sanitation services to each resident.	

OBJECTIVES	*CONTENT*	*ACTIVITIES*
	j. Improper facilities and inadequate maintenance will eventually create slum areas. k. The establishment of zoning laws has somewhat alleviated many problems which result from a rapid expansion of population area. l. State legislatures enforce guidelines on sanitation facilities and their improvement. m. Some states have taxes on utilities to provide adequate facilities for those who are unfortunate, and also to establish good sanitary practices. n. It is of vital importance that good sanitary practices be established and maintained in rural areas not only as a health measure, but also as protection against fires and other hazards.	
4. To gain information relative to mental health and retardation problems and needs.	4. *Mental Health and Mental Retardation Problems and Needs.* a. Some persons feel that the mentally ill constitute the number one health problem in the United States. b. The concept of treatment of the mentally ill has moved from hostile, custodial care to the development of a therapeutic milieu in the hospital, half-way house, or home setting. c. Mental disorders: (1) Psychosis – a generic name for a mental disorder of the more serious type; usually requires hospitalization. Loss of contact with reality. (2) Neurosis – a mental disorder of the less serious type; usually does not require hospitalization. (3) Schizophrenia (psychosis) – split personality; split in mental functioning, retreat from reality. (4) Manic-depressive (psychosis) – emotional instability, striking mood swings, tendency to recurrence. (5) Schizoid (neurosis) – shyness, introspective personality. (6) Amnesia – pathologic loss of memory. (7) Alcoholism – the overuse of alcohol to the extent of habituation, dependence, or addiction.	

(8) Compulsive personality (neurosis) – adherence to rigid standards; overconscientious.

(9) Senility – chronic brain disorder caused by a generalized atrophy of the brain due to aging.

(10) Epilepsy – a disorder characterized by periodic motor or sensory seizures sometimes accompanied by a loss of consciousness.

(11) Hypochondria (neurosis) – persistent overconcern with the state of physical or emotional health accompanied by various bodily complaints.

(12) Mental retardation – lacking in intelligence to a degree that one cannot make an average adjustment to life.

  (a) Borderline 70-85 I.Q.

  (b) Moron 50-69 I.Q.

  (c) Imbeciles 20-49 I.Q.

  (d) Idiots 20 and below I.Q.

(13) Depression (psychosis or neurosis depending on degree) – Morbid sadness, dejection, melancholy.

(14) Homosexuality–sexual attraction to same sex.

(15) Mania (psychosis) – heightened excitability, acceleration of thought, speech, and bodily motion, elation, grandiosity of mood.

(16) Paranoia (psychosis or neurosis depending upon degree) – internally logical system of persecutory and/or grandiose delusions.

d. For some time the causes of mental illness were unknown. In recent years some mental illnesses are known to be associated with infections, heredity, genetic problems, and physical abnormalities.

e. Extent of problems.

(1) It is estimated that one out of every ten persons will spend some part of his life in a mental hospital.

(2) It is estimated that mental illness has a prevalence rate among urban populations of 1%.

(3) Schizophrenia – approximately 220,000 persons were hospitalized in 1960, forming the largest category among hospitalized patients. Of course, many were not hospitalized.

(4) Manic-depressive–of all first admissions to mental hospitals, this group accounts for about 10%.

(5) Chronic brain syndrome, senility–accounts for approximately 40% of all admissions to mental hospitals.

f. Needs.

(1) Innovative methods of care.

(2) Nonhospital treatment facilities – half-way houses, home care programs, outpatient clinics, half-day treatment facility.

(3) Additional hospital beds for the mentally ill.

(4) Incorporation of mental health programs in comprehensive health programs.

(5) Up-dating of mental health laws.

(6) Community mental health programs geared to the needs in the local community.

References on Community Health Problems and Needs

1. Hanlon, John L. *Principles of Public Health Administration.* 4th ed., St. Louis: C. V. Mosby Company, 1964.

2. Mustard, Harry S. and Stebbins, Ernest L. *An Introduction to Public Health,* New York: Macmillan Co., 1959.

3. Katz, Alfred and Felton, Jean. *Health and the Community.* New York: The Free Press, 1965.

D. COMMUNITY RESOURCES

Overall Objective:

To gain skill in utilizing community resources.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
A knowledge of the health facilities and, to some extent, the social facilities available in the neighborhood.	STUDYING COMMUNITY RESOURCES This unit applies the general information presented in the public health administration section to a study of the local community. Its purpose is to enable the trainees to acquaint themselves with the health and social facilities of the community they will serve so that they can properly utilize these resources in the performance of their duties. A list of the facilities to be studied should be obtained from the local public health department by the trainer. This list can then be categorized according to the need which each facility serves, e.g., eye clinics, well baby clinics, child guidance clinics. In this way, all the facilities available for meeting a particular need can be presented and discussed in conjunction with a discussion of the particular health problem involved. For instance, when discussing infectious disease and the importance of immunization, the trainer will mention the vaccination services available to the community. The trainees should visit some of the health and service agencies, acquainting themselves with procedures and gathering materials concerning the services rendered by the agency.	Trainer to obtain list of health and social services available from local public health department.
	THE COMMUNITY RESOURCE FILE The trainees are to work together to compile a community resources file. The information they collect at the agencies visited with the class and in their work with families utilizing the community services should be augmented by telephone inquiries so that a complete file of the community resources will be available to all the aides. The trainee manual contains an example of a resource file card. Note that it is only a sample, describing a particular service agency in Washington, D. C. Emphasize to the trainees that a complete file on a health or social facility involves a listing of place, hours, services rendered, eligibility requirements, the method of obtaining service, fees, and any additional information pertinent to an efficient use of the facility.	Trainer to obtain for distribution to trainees any pamphlets or guides concerning the facilities available in the community. Encourage the health aides to carry these materials with them and use them in the performance of their duties. Refer to trainee manual, p. 193, for the sample resource file card. Trainer to complete a duplicate form using information about a local facility.
	PUBLIC HEALTH NURSING Acquaint the trainees with the function of the public health nurse and the visiting nurse. Describe the duties which they perform: bed baths, injections, exercises, etc. Indicate their importance as health instructors in the community. Discuss cases with which the trainees are familiar in which public health nurses and visiting nurses are giving service. Visit the offices of the public health nurse and the Visiting Nurses Association.	

E. ENVIRONMENTAL HEALTH AND HOME SANITATION

Overall Ojective:

To gain an understanding of insect control, various waste disposal methods, and other environmental health aspects.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To gain an understanding of ways to protect foods.	1. *Food protection* a. Growth of infectious microorganisms may develop on perishable foods if they are not properly refrigerated. b. Foods such as milk and milk products, eggs, meats, poultry, fish and moist combinations of these foods should be kept cold 45°F or below or hot 140°F or above. c. Pork should always be thoroughly cooked. d. Fruits and vegetables should be washed thoroughly before use. e. All foods should be protected from contamination. f. Nonacid and low-acid home canned foods should be boiled before using. g. Persons handling foods should wash their hands before doing so.	1. Sanitary engineer to give lecture. Group discussion. Specific examples pointed out by sanitary engineer and trainees.
2. To gain an understanding of a safe water supply.	2. *Water supply* a. A safe and adequate water supply is one of the primary requirements of healthful living. b. Persons living in large cities usually have a better and more sanitary water supply. c. In rural areas people should take precautions to safeguard their water supply from becoming contaminated. d. Typhoid fever, dysentery, and cholera may be caused by germs which are carried from the intestinal discharges of infected persons into the drinking water. e. The local health department should be consulted for the best methods of preventing water pollution. f. In areas having no local health department, advice may be obtained from the state health department, state university, or regional Public Health Service office.	2. Visit the source of water supply in the local community with sanitary engineer. Observe purification process.

OBJECTIVES	CONTENT	ACTIVITIES
3. To gain an understanding of methods of sewage disposal. Local rules and regulations.	3. *Sewage disposal* a. Indoor toilets are more convenient and sanitary than outdoor toilets. b. They should be kept clean, well lighted and well ventilated. c. Wash hands after using toilet. d. Flies, rodents, and farm animals spread diseases. e. Wastes from water-flush toilets not connected to a public sewer system are best disposed of by the use of a septic tank. f. Facilities not flushed by water include pit privies, concrete vault privies, chemical toilets, and pail or can-type privies. g. Advice on proper facilities and those best suited to local conditions may be obtained from local or state health departments.	3. Lecture by sanitary engineer. Examples and questions by trainees.
4. To gain an understanding of proper refuse disposal.	4. *Refuse disposal* a. In urban areas garbage should be wrapped in newspapers and collected twice a week to prevent or reduce flies, rodents, and odor problems. b. A garbage disposal is a quick and convenient method to dispose of garbage, although other refuse still has to be collected. c. Metal containers with tight fitting covers and suitable handles should be used for garbage. d. These containers help to improve sanitation and reduce labor required for collection. e. Outside of urban areas, regular refuse collection service may not be available. f. Each householder must haul his refuse to a public disposal site, or dispose of it on his own property. g. Garbage grinding, household incineration, burial, backyard composting, and feeding to animals are commonly used household disposal methods. Refuse should never be dumped on the ground where it will attract flies and rats or become a fire hazard. h. Six simple steps in handling garbage, rubbish, and other refuse. (1) Providing and using proper containers. (2) Maintaining the containers in a sanitary condition.	4. Lecture by sanitary engineer. Local rules and regulations. Trainees will discuss the situation as it exists in their neighborhood.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
	(3) Placing the containers in the right place at the right time. (4) Draining and wrapping garbage in newspapers and bundling bulky rubbish. (5) Where required, separating garbage, ashes, and rubbish. (6) Removing any trash from yard, basement, or attic each week and setting it out for collection.	
5. Insect and rodent control.	5. *Insect and rodent control* a. Try to keep flies from entering the home by proper screening of doors, windows, and other openings. b. Screen wire with 16 meshes per inch will keep out flies and mosquitoes. c. The best method of fly control is the elimination of their breeding places. d. Attention to manure piles and open privies, as well as prompt removal of cut grass and refuse, is important. e. Stagnant water should not be permitted near a dwelling, especially where water stands in broken bottles or open cans. f. Areas of water serve as breeding places for mosquitoes. g. Ratproof construction of houses, elimination of places where rats breed and hide, and storage of food supplies in closed containers are essential in controlling rats. h. Efficient chemicals are available to kill insects, rats, cockroaches, bedbugs, and other vermin. i. The instructions for their use should be carefully followed, and they should always be kept out of reach of children. j. Professional exterminators may be used to eradicate household pests.	5. Lecture by sanitary engineer. Discuss local rules and regulations.
6. To gain an understanding of environmental health as it pertains to light and ventilation, heating, and plumbing.	6. *Light and ventilation, heating, and plumbing* a. Light and ventilation. (1) Sunshine and fresh air are highly beneficial to health and comfort. (2) Every room should have at least one window which can be opened for ventilation.	6. Lecture by sanitary engineer. Health aide trainees to discuss examples.

OBJECTIVES *CONTENT* *ACTIVITIES*

(3) Bedroom overcrowding is undesirable and results in the spread of diseases.

(4) Homes should have good artificial lighting and lots of window light.

(5) Cellars should be kept clean and aired sufficiently to prevent dampness.

(6) Leaky pipes should be repaired immediately.

(7) Dampness and low temperatures may lower the normal resistance of individuals to colds and other respiratory infections.

b. Heating.

(1) The temperature of a room should always be comfortable.

(2) The most favorable temperature depends on the humidity and air movement.

(3) A temperature of 68° with a humidity of 50% is satisfactory.

(4) Great temperature differences between different levels of a room should be avoided.

(5) 68°F temperature should be maintained for both foot and head levels.

c. Plumbing.

(1) All drainage pipes should be kept open and free from obstruction.

(2) Garbage should never be disposed of in the toilet bowl, for this causes clogging of the pipes.

(3) Backflows of wastes into the water system often occur in improperly installed plumbing systems.

(4) Home plumbing should be installed in accordance with local plumbing codes.

Films and Filmstrips on Environmental Health

All materials can be obtained from the United States Government Printing Office, Washington, D. C. Some of them may be obtained in quantity for distribution to the trainees.

1. *Fly Control Through Basic Sanitation* (motion picture) U.S. Public Health Service, 1960.
2. *Food Sanitation Part 4: Refrigeration and Food Handling* (filmstrip) U.S. Public Health Service, 1954.
3. *Kitchen Habits* (motion picture) U.S. Public Health Service, 1954.

4. *Environmental Sanitation* (motion picture) U.S. Office of Inter-American Affairs, 1945. Made by Walt Disney Productions. Re-released by U.S. Institute of Inter-American Affairs, 1946.

5. *Disease and Personal Hygiene* (motion picture) U.S. Dept. of the Army, 1948. Released for public education use through U.S. Office of Education, 1949.

6. *Municipal Sewage Treatment Process* (motion picture) U.S. Public Health Service, 1951.

References on Environmental Health

1. Hollis, Mark: "Environmental Health Needs in a Dynamic Society," *Publ. Health Rep.* 67:903, Sept. 1952.

2. Hollis, Mark: "Aims and Objectives in Environmental Health," *Am. J. Publ. Health* 41:264, March 1951.

3. Hollis, Mark: "Environmental Health in a Rural Economy," *Publ. Health Rep.* 68:1108, Nov. 1953.

4. Board, L. and Dunnore, H.: "Environmental Health Problems Related to Urban Decentralization," *Am. J. Publ. Health* 38:986, July 1948.

5. "Report of the Committee on Environmental Health Problems," *Public Health Service Publ.* No. 908, 1962.

6. "Environmental Health, Washington, 1951," *Public Health Service Publ.* 84.

7. Johnson, R. J.: "Health Departments and the Housing Problem," *Am. J. Public Health* 42:1583, December 1952.

8. "Basic Principles of Healthful Housing," 2nd ed., New York, 1941, American Public Health Association.

9. *Environmental Health Planning Guide:* health agency operations, planning agency, air pollution control, housing programs, radiological health, refuse collection and disposal sanitation program, sewage services, water supply service. Rev. 1962. 60 p. illus. 45¢

10. *Hot Tips on Food Protection.* 1966. 6 p. illus. 10¢

11. *You Can Prevent Foodborne Illness.* 1964. 6 p. 5¢

12. *Home Sanitation.* Rev. 1962. 6 p. illus. 5¢

F. REFERRALS

Overall Objective:

To develop skill in implementing referrals to health agencies.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To understand the definition and concepts of the referral process.	1. *Referral* a. A written or verbal communication to direct a person to a facility. b. The referral process takes into account the health need, the financial resources of the patient, the services available within the facility, and the time and place of the service. c. Whatever method is adopted for the referral it should meet the following criteria: (1) Be fast enough to avoid unnecessary lapse in time for care to be received (2) Be personal enough to make the transfer easy for the patient and the facility (3) Be simple enough to avoid unnecessary paper work, yet provide the necessary information to meet agency's requirements. d. A referral form may be standardized for the entire community, or it may be specific to each individual agency. e. A telephone referral has the advantage of speed and personalization, and it also provides the opportunity for immediate clarification. f. The written referral provides a permanent record for the agency; and in addition, the patient feels secure in that "he has something to take with him." g. Referral forms may vary in format from a very extensive record to a simple one with one sentence. h. The referral must always meet the needs of the person referred and the agency that provides care. i. A health aide must be thoroughly familiar with all of the facets of a facility; care rendered; eligibility requirements; fees for service; place, date, and time of service; and procedures for follow-up if necessary.	1. The health aide trainer will relate the concepts of a referral. Group discussion with personal experience of receiving referrals brought out in discussion. During on-the-job training health aides will make frequent use of referrals.

OBJECTIVES *CONTENT* *ACTIVITIES*

j. The person who initiates the referral assumes the responsibility to follow up the referral to determine if the appropriate care is received.

2. *To Understand When a Referral Is Needed*

   a. A referral is necessary whenever the agency or department of the agency in which the health aide is employed does not render the health care needed by the patient and/or family. Since the community health aide does not provide direct patient care, a referral will almost always be necessary.

   b. Even though the facility operates on an open appointment basis, a referral is the preferred method when sending a patient to the facility.

   c. If the facility does not require a written referral, the patient may desire one and/or feel more secure with a referral.

   d. Most agencies require or prefer a written referral, but the health aide should always check with the agency to determine its policy.

3. To develop skill in making a referral.

3. *Referral Method*

   a. Ascertain if the needs of the patient can be met at the health or health-related facility.

   b. Determine the requirements of the agency to whom the patient will be referred prior to making the referral.

   c. For a written referral, ascertain all of the information from the patient and/or from records to meet the requirements of the agency.

   d. Clear with the facility for a specific time, date, and place. If possible obtain the name and title of the person that the patient is to see.

   e. Find out if it is convenient for the patient to keep the appointment that is given.

   f. Complete the written referral form. The minimum information that is generally needed is:

      (1) Name of patient

      (2) Birthdate of patient

      (3) Address and telephone of patient

      (4) Health problem

      (5) Name and address of facility

      (6) Date and time of appointment

OBJECTIVES	CONTENT	ACTIVITIES
	(7) Referring agency and address (8) Name of worker who referred patient (9) Telephone number of referring person. g. Provide patient with necessary verbal instructions for following through on referral. h. Make sure patient has means of transportation and understands how and where to go. i. If appointment is far in advance, telephone patient to remind him of appointment at least one week in advance.	
4. To understand the importance of following through on a referral.	4. *Follow-up on Referral* a. It is always the responsibility of the person making the referral to follow-up. b. Determine if patient was unable to keep the appointment. c. If appointment was not kept, and problem still persists, make another referral, and, if possible, eliminate the reason for failure to keep the appointment. d. If appointment was kept, ascertain if health problem was solved, if further care is necessary, or if periodic checks are recommended. e. Review next steps to be taken with patient and continue surveillance until the health need is met.	

References on Referrals

1. Freeman, Ruth B. *Public Health Nursing Practice.* Philadelphia, W. B. Saunders Co. 1957.

2. Bohaut, Yetta and Mahoney, Isabel. "A Referral Plan That Serves Babies," *The American Journal of Nursing* LX, No. 6, June, 1960, pp. 824-27.

G. ELIGIBILITY REQUIREMENTS FOR COMMUNITY HEALTH PROGRAMS

Overall Objective:

To gain knowledge of the procedures for determining eligibility requirements for assistance in community health programs.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To understand the basis for eligibility requirements.	1. *Basis for eligibility requirements.* a. Official health agency rules and regulations determining what type of person is eligible for part-pay care or free care, are established by the local governing body. b. Rules and regulations that determine the types of persons eligible for care in a private health agency are decided by its Board of Directors. c. The bases for eligibility requirements are generally determined by the kind of financial support the agency receives. (1) Official – tax funds. (2) Private – fees for service, United Givers Fund, endowments, contractual agreements. d. Generally the official agency provides various types of care to different segments of the population. For example: free chest x-rays to anyone who desires; hospitalization for residents who meet certain low-income criteria; out-patient clinic care for residents who meet certain income requirements; immunizations for anyone who satisfies an age limitation. e. Depending on how liberal the board of directors is, a private health agency is generally very selective about the patients to whom it provides care. The budget size plays an important role in determining eligibility of patients.	1. Group discussion with introduction by health aide trainer. Following the introduction, a health aide with personal experience will assume the leadership for the group. During on-the-job training, all health aides will have sufficient opportunity to develop skill in this area.
2. To understand the relationship between the requirements and source of authority.	2. *Relationship between the source of authority and the eligibility requirements.* a. Source of authority – governing body; determination of eligibility requirements. b. Official agency – laws promulgated by governing political body. c. Private agency – regulations and policies set by board of directors. d. When the source of authority is a political body there is little flexibility in the criteria developed.	

OBJECTIVES	CONTENT	ACTIVITIES
	e. In the case of private agencies, some boards of directors allow a great deal of flexibility in applying eligibility rules, whereas others are quite rigid.	
3. To gain understanding of the procedure for determining eligibility requirements.	3. *Method for determining eligibility.* a. The procedure will vary according to the criteria of the specific health agency. b. The criteria may range from no restrictions to a residence requirement and a certain income level. c. Hypothetical situation – the criteria is one year's residency plus a total gross family income as determined by the local governing body. (1) Establishment of residence: (a) Rent receipts (b) Affidavits by neighbors (c) Welfare Department records (d) Health Department records (e) Private agency records. (2) Establishment of income level: (a) Gross income stubs from all family members (b) Verifications by employer (c) Public housing records (d) Other official agency records.	
4. To develop skill in assisting families to establish eligibility.	4. *Role of the Health Aide.* a. Interprets to families the eligibility requirements of a health facility. b. Explains to families the meaning of and reason for verifying residence and income. c. Assists families in gathering receipts, record information, neighbor affidavits, and other requirements. d. If necessary, accompanies patients when they go to prove residence and income level.	

References on Eligibility Requirements

1. Ruth B. Freeman, *Public Health Nursing Practice.* Philadelphia: W. B. Saunders Co., 1957.

H. ASSISTING PATIENTS TO COMMUNITY HEALTH SERVICES

Overall Objective:

To develop proficiency in assisting various categories of patients to community health services.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To understand the need for the service.	1. *Need for service.* a. Elderly patients, blind patients, mentally retarded patients, and other categories sometimes are unable to avail themselves of health services because they need someone to accompany them. b. Many health facilities do not offer this type of service.	
2. To understand the precautions to be taken while assisting patients to community health services.	2. *Precautions to be taken in assisting a person to a health facility.* a. Check with facility for exact time and place of appointment. b. Inquire from medical doctor, public health nurse, or supervisor whether special means of transportation are necessary – examples: ambulance, wheelchair. c. Make sure the patient has such things as clinic pass, health record, specimens, prescription bottles, etc. when required or desirable during the visit to the health facility. d. Have some means of identifying yourself as a health aide. (Quite helpful when visiting patients for first time and when health facility personnel inquire regarding the agency the trainee represents.) e. Inquire from patient and use own judgment to determine whether the patient's condition will allow him to be taken to a health facility. f. Write name of facility, telephone number and doctor's name on a sheet of paper and leave in the home with other family members. g. When desirable, alert health facility personnel that you are on the way with the patient.	2. Each aide is to be assigned patients for on-the-job training purposes who require this type of service.
3. To develop skill in assisting patients to health facilities.	3. *Assisting patients to health facilities.* a. Patient with appliances on lower extremities, crutches, cane, other walking aids and/or difficulties in ambulation:	

(1) Ask patient if he wants you to hold his hand, help him in and out of cars or buses, and open doors. Over-assistance may make him anxious and resentful.

(2) When the patient is going downstairs, precede him; when going upstairs go behind him, to provide support if he slips or falls.

(3) In some cases a male health aide or two female health aides may be required in order to safely assist a person who has difficulty ambulating.

b. Blind or partially-blind patients:

(1) Ask if patient wants you to walk on his right or left side.

(2) Hold right or left arm immediately below elbow (depending on patient's preference) to guide him.

(3) If patient is trained to travel with a dog or unassisted, do not attempt to lead him. Give him information regarding red and green lights, traffic conditions, available seating space, etc.

(4) In handling money for blind persons make change in all one dollar bills and coins, unless the patient specifies otherwise. This is helpful for the patient in determining the amount of money he has.

c. Patients who require medications at regular intervals such as diabetics, cardiacs, epileptics:

(1) Inquire whether he took appropriate medicine prior to leaving the house. If not, encourage patient to take the medicine.

(2) Take at least a day's supply of medicine to the health facility with the patient.

(3) If patient will not be with you at all times, make sure he has the medicine on his person while not in your presence.

d. Patients with speech and hearing difficulties:

(1) If patient reads lips, face him while you are talking.

(2) Write instructions on note pads if this facilitates communications.

(3) Ask people at the health facility to put all instructions in writing.

OBJECTIVES	CONTENT	ACTIVITIES
4. To develop an awareness of the need to exchange information with personnel while visiting the health facility.	4. *Exchange of information.* a. The health aide is often the only link between the patient and the health facility. b. Because of the unique position of the health aide in the community he may be the only health worker with whom the patient converses without reservation. c. In order to effectively meet the health needs of the patient, the physician must be cognizant of the progress or regression of the patient's condition. d. Many patients are unable or are reluctant to relate their health problems and needs to professional health workers. The health aide can provide this information during the visit.	

I. CARE OF OTHER FAMILY MEMBERS

Overall Objective:

To develop skill in carrying out various procedures and precautions while staying in the home with other family members while the patient attends a health facility.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To understand the need for caring for others in the home while patient visits health facility.	1. *Need for caring for others in the home while patient attends health facility* a. Has long been a detriment to obtaining health care: (1) Mother unable to afford cost of babysitter (2) Inability of family to find a competent person to care for an elderly, ill person while the head of household is away from home. b. Will decrease the anxiety of the patient while away from home. c. Will afford the opportunity for an informed person to stay with children and adults while the head of the household seeks health care. 2. *Precautions to be taken* a. Ask for special instructions in writing if situation demands it while caring for the children or adult. b. Health aide must *never* give any type of medicine (orally or otherwise) without specific instruction from supervisor. (Supervisor must clear with physician and obtain agency authorization to allow health aide to assist patient in taking medicine.) c. Feeding instructions are to be obtained from head of household. d. In case of infant – check for supply of diapers, change of clothing. e. Obtain name and telephone of relative or close friend of family. f. Obtain name and telephone of doctor if applicable. g. Have close at hand, telephone number for fire and police departments.	1. To be discussed immediately prior to health aides assuming this function. In group discussion, health aides can discuss their experiences in babysitting or watching elderly persons in the home. The aides should be encouraged to discuss problems encountered and solutions to problems during their experiences. Health aides can enumerate additional precautions to be taken.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
3. To develop skill in caring for children.	3. *Procedure for caring for children* a. Try to prevent accidents before they happen: (1) Make sure children stay away from matches, electric switches, cords, fire. (2) Place medicines out of reach. (3) Keep children away from windows. (4) Keep floor and stairway free from toys. (5) Close gate at top of stairs. (6) Don't allow children to run. (7) Use no loose plastic covers near children. (8) Never leave children unattended near water. (9) Don't leave lit cigarette within reach of children – it is best not to smoke on the job. (10) Keep pointed objects out of child's reach. b. Feed children as directed by mother: (1) Wash hands before preparing food. (2) Wear apron if you prefer. (3) Allow children to eat at their own pace. (4) Assist infants with their food. (5) Older children can assist in feeding the younger ones. c. Change clothing as instructed by mother, or if soiled by food during the feeding. Infants – change diapers as often as necessary. Cleanse bottom before putting on clean diaper. d. Put children to bed as instructed by mother: (1) Most young children are accustomed to an afternoon's nap. (2) Infants – be sure to pull up side rails on crib. (3) Older children can assist in preparing younger children for bed.	3. Health aides to discuss additional procedures.
4. Health aides to discuss additional procedures with qualifying statements from trainer.	4. *Procedure for caring for elderly/ill adults* a. Obtain instructions regarding feeding, elimination and routine of daily care.	4. To develop skill in caring for adults in the home.

OBJECTIVES	CONTENT	ACTIVITIES
	b. If person is able, encourage him to assist you as much as possible in providing care.	
	c. Since the community health aide is not trained to carry out bedside care activities, only those bedside care activities authorized by the trainer/supervisor may be performed. (The trainer/supervisor is responsible for assuring that the health aide possesses the required knowledge and skill to provide safe bedside care.)	
	d. Any type of care outside of elimination and feeding activities should be recorded and a written record left in the home before departure of the aide.	

Suggested References

1. *When Teenagers Take Care of Children; A Guide for Babysitters.* U.S. Department of Health, Education and Welfare, Welfare Administration Children's Bureau, Washington, D. C.
2. Austin, Catherine. "The Basic Six Needs of the Aging," *Nursing Outlook,* VII, No. 3, March 1959, 138-142.
3. John Hancock Mutual Life Insurance Company. *Diversions for the Sick.* Boston, Massachusetts.

J. INTERDISCIPLINARY CONFERENCES

Overall Objective:

To develop skill in functioning effectively
at an interdisciplinary conference.

OBJECTIVES

1. To gain an understanding of interdisciplinary conferences.

CONTENT

1. *To Understand the Meaning of Interdisciplinary Conferences.*
   a. When family problems are extensive and require the services of many agencies and disciplines, a case conference may be held by an agency or agencies to find ways of solving the problems.

   b. Example: a school-age child has a positive tuberculin test; his mother is hospitalized for tuberculosis in municipal tuberculosis hospital. A case conference may be called to decide on the proper place of care for the school-age child. Persons attending the interdisciplinary conference may include:

      (1) Family physician

      (2) Public health nurse

      (3) Hospital nurse

      (4) Hospital social worker

      (5) Health aide

      (6) Teacher

      (7) School counselor.

   c. Quite often, the adult patient or the parent of the sick child will be asked to come in so the decision of the conferees can be explained to him. This affords the committee the opportunity of immediately perceiving the reaction of the person. Also, the person can receive immediate clarification regarding unclear points.

2. *The Conference.*
   a. The one who initiated the conference should bring the meeting to order and discuss the purpose of the meeting.

   b. There should be a brief presentation of the case history of the patient and/or family.

   c. Then the case can be discussed.

ACTIVITIES

1. The health aide trainer will discuss with the group the purpose of an interdisciplinary conference.

   Trainees can discuss their personal experiences with respect to interdisciplinary conferences.

   During on-the-job training, the health aides will participate in conferences, and may, under close supervision, initiate them.

OBJECTIVES	CONTENT	ACTIVITIES
	d. A person should be designated to take notes so that a permanent record will be available of the contributions, recommendations, and decisions of the group members. e. The conference should conclude with a summary of the decisions made and a statement of the responsibility to be assumed by each agency representative. f. A written report should be sent to each participant.	
3. To understand the role of professional persons involved in the interdisciplinary conference.	3. *Role of the Professional.* a. The professional always has the ultimate responsibility for the quantity and quality of care provided the patient or family. b. The professional will contribute information regarding care and problems as they relate to his specialty. Example: Public health nurse will discuss nursing care in the home and the problems involved in giving family health care. c. May or may not assume the leadership role.	
4. To understand the role of the health service aide in the interdisciplinary conference.	4. *The Role of the Health Aide.* a. The health service aide may or may not assume the leadership role. b. The health service aide will contribute information regarding the care provided and the problems he has encountered in working with the patient's family. The health aide is in a unique position to provide other committee members with information and problems that the patient or family found easier to discuss with him. Many times the health aide will enlighten the professional participants about problems in a specific neighborhood; feelings of the patient/family toward authority figures, and other areas that would otherwise not be known to the professionals. Example: The mother was reluctant to inform the public health nurse that her child missed the well baby clinic appointment because she did not have money for shoes; on the other hand she willingly discussed the problem with the health aide. c. The health aide assumes partial responsibility for the care provided the patient/family.	

OBJECTIVES	*CONTENT*	*ACTIVITIES*
5. To gain an understanding of the importance of information sharing.	5. *Information Sharing.* a. Information sharing is the technique used in the conference. b. The quantity and quality of information sharing is usually directly related to the effectiveness of the conference. c. Each participant must have the opportunity to contribute to the conference.	
6. To understand the importance of follow-up.	6. *Follow-up.* a. The purpose of an interdisciplinary conference is to bring various agency representatives together to solve a problem. The conference is a means to an end; not the end itself. b. Following the conclusion of the conference, each participant assigned a particular function should keep all members abreast of his progress. c. The problem may be of such a nature that additional conferences are necessary. d. One person should be delegated the responsibility for ensuring that the follow-up measures are carried out.	

References on Interdisciplinary Conferences

1. Freeman, Ruth B. *Public Health Nursing Practice.* Philadelphia: W. B. Saunders Co. 1957, pp. 3-31.

2. Peplau, Hildegard E. *Interpersonal Relations in Nursing.* New York. G. B. Putnam's Sons. 1952. pp. 330.

3. Bureau of Medical Services and Hospitals. *A Study of Nursing Home Care in Maryland.* Baltimore, Md: Maryland State Department of Health, October 1960.

4. *Concepts of the Behavioral Sciences in Basic Nursing Education.* Proceedings of the 1958 Regional Conference on Psychiatric Nursing Education. New York: National League for Nursing, 1958.

5. Glifford, Alice J. *Unity of Nursing Care. A Report of a Project to Study the Integration of Social Science and Psychiatric Concepts in Nursing,* Chapel Hill, N. C.: The University of North Carolina School of Nursing, June, 1960.

K. COMMUNITY ORGANIZATION

Overall Objective:

To develop skill in community organization as it relates to health.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To understand the meaning of community organization.	1. *Community organization* a. Community organization is the arranging and developing of human resources in a specified neighborhood to attack a common health problem. b. Community organization should proceed in an orderly manner. c. A community organization effort should involve all segments of the population in the prescribed area. d. Community organization necessitates that the persons involved be informed regarding the issue and alternatives for action. e. Energies of persons involved in community organition must be channeled toward a positive, constructive goal in solving a problem. Unchanneled energies among a group of aroused persons may be dangerous and destructive.	1. The trainer will provide the health aides with material regarding community organization. All health aides will be involved in a community organization project. Discuss their experiences and evaluate outcomes. During the on-the-job training component the health aides will gain experience in community organization. The health aide supervisor will be very supportive in this area and will coordinate with other health and related workers who are involved in community organization to prevent overlap.
2. To understand the need for such activity in the health area.	2. *Need for community organization in the health field* a. Traditionally there has been little community organization (organized at the grass roots level) in the health field except for the areas of communicable disease and environmental sanitation. In the latter instance fear was the motivating force and many times the community organization efforts were little more than a mass hysteria. b. Sometimes the health care available does not keep pace with the need. Aroused public action may bring pressure on the authorities to correct the situation.	
3. To gain understanding of appropriateness of problems selected.	3. *Appropriateness of problem area* a. Selection of the problem area should depend upon several factors: (1) The magnitude of the problem in the local area (2) The interest of the persons in the prescribed neighborhood	

OBJECTIVES	*CONTENT*	*ACTIVITIES*
	(3) Whether or not the community organization effort is the best means of bringing about a desirable change in the situation. (4) Timing is a very important factor. It is useless to initiate a community organization effort regarding a budget item after the budget has been approved. An issue regarding a proposed change in a school health program is better raised prior to the implementation of the program.	
4. To gain insight into the method of determining a health problem to attack.	4. *Method of determining health problems to attack* a. Discuss a "felt" health problem with the public health nurse, health educator, sanitarian or other health professional in the particular neighborhood. From such a discussion you may discover that the professional is just as interested as you are in correcting the situation. The professional may advise you that another means of attacking the problem would be more effective, or that plans are underway to correct the situation. b. Discuss the problem with the health aide supervisor to determine his feeling regarding the health problem to attack. It may be discovered that another health problem would have priority at the time. c. Discuss the problem with persons in the neighborhood (some persons may have already approached you) to determine their interest and how they feel the problem affects them. d. The supervisor will provide the final guidance as to whether or not the area selected is an appropriate health problem to attack through community organization efforts.	
5. To understand the relationship of the selected health problem to the existing health program.	5. *Relationship of selected health problem to the existing health program* a. A health program may be in existence that is designed to solve the health problem selected. b. A health program may be in existence that addresses itself to the health problem, but not the age group or persons the health aide is interested in. c. No organized health program is in existence that addresses itself to the health problem selected. d. It is vitally important that the health aide understand the relationship of the selected problem area to the existing program; the health aide should make every effort to coordinate and plan with the persons responsible for operating the existing program.	

OBJECTIVES	CONTENT	ACTIVITIES
6. To gain skill in organizing a group of interested persons.	6. *Organizing a group of interested persons*	
	a. Determine persons in the neighborhood interested in the problem who have leadership potential.	
	b. After two or three persons with leadership potential express an interest, enlist their support in organizing their peers.	
	c. If the selected health problem has several facets, persons interested in the same facet can be organized in a sub-group. Example: Inadequate prenatal care subgroups: (1) Eligibility requirements (2) Decentralized services (3) Evening clinics (4) More clinic sessions in a given neighborhood (5) Wider range of services offered.	
	d. Call meeting with nucleus group to discuss strategy. Make the time and place of the meeting convenient for the participants.	
	e. After nucleus group decides on strategy, call larger meeting with as many interested neighborhood persons as can be encouraged to come.	
7. To gain some insight into the principles of group dynamics.	7. *Selected principles of group dynamics*	
	a. Share the leadership role with other members of the group.	
	b. Encourage "silent" members to contribute to the discussion.	
	c. Have an agenda in mind; have a definite idea of what you would like the group to accomplish during the session. The agenda should be flexible enough so that pertinent points or points of more interest to the group can be discussed.	
	d. Allow participants to voice opposing view points. Negative points tend to focus more sharply the point under discussion.	
	e. Encourage as many different persons to contribute to the discussion as possible.	
8. To understand the necessity of sound planning with group and health agency.	8. *Necessity of sound planning*	
	a. Sound planning can mean the difference between success or failure of a community organization effort.	

OBJECTIVES	CONTENT	ACTIVITIES
	b. Sound planning contributes to confidence in you as a health aide and as the group leader.	
	c. Sound planning prevents wasting the participants' time in performing planning activities that are the responsibility of the staff health aide.	
	d. Sound planning with the health agency enhances the chances of enlisting the support and cooperation of the health agency.	
	e. Sound planning with the health agency often is useful in preventing mistakes.	
9. To develop skill in implementing a community organization effort.	9. *Process of community organization*	
	a. Select appropriate health problem; define objectives.	
	b. Organize nucleus group.	
	c. Organize total group.	
	d. Plan with group and health agency.	
	e. Implement action to accomplish objective.	
	f. Evaluate effectiveness of action taken. (1) To what extent was objective accomplished? (2) Is there a need for a different approach? (3) Is a continuous effort necessary?	
	g. Recommendation for further action (follow-up).	

L. GROUP TEACHING

Overall Objective:

To gain skill in providing health instructions to an aggregate of individuals.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To understand the principles of learning and teaching.	1. *Principles of learning* a. Learning transfer: learning is meaningful only when the student understands, can apply, and transfer what he learns from academic to life situations. b. For learning to be effective, the student needs to see a clearly defined goal, accept it, and direct his activities toward its attainment. c. The learning process proceeds most effectively when the learning situation is adjusted to the individual needs of the student. 2. *Principles of teaching* a. The teacher must make the material interesting in order to teach it. b. While performing her duties, the nurse should recognize and use opportunities for teaching. c. The content of health teaching should be adapted to the level of comprehension of the learner. d. The information should be given in such a way that it is acceptable to the family. e. Learning is more effective under conditions of undivided attention. f. Effective health teaching must be explicit. g. Repeating and emphasizing important points strengthens learning. h. Pace the instruction to suit the family. i. Efficient instruction should be systematically planned but sufficiently flexible to meet changing needs. j. Effective use of visual aids is a valuable adjunct in health teaching. k. The salient points of the material should be summarized at the conclusion of the instruction. l. The results of teaching should be evaluated.	1. The health aides are to give practical examples of each principle after a clear explanation by the trainer.

OBJECTIVES	CONTENT	ACTIVITIES
1. To develop skill in group teaching.	GROUP TEACHING 1. *Definition and concepts* a. Group teaching is the imparting of knowledge to more than one individual at the same time. b. The purposes of group teaching may be directed to various ends, for example: developing skills; changing habits, attitudes; providing knowledge; developing understanding. 2. *Organization of interested persons in the community* a. While performing daily duties, be alert to those persons who express a desire to improve a certain condition prevailing in the neighborhood. b. Assess the abilities and potentials of persons with whom you are in contact. Tentatively select persons with leadership potential. c. Discuss problem or issue with various persons to obtain their reactions. Those who express strong feelings may form the "nucleus" of the group and help interest others in participating in the group class. d. After a sufficient number of persons express a desire to avail themselves of group teaching, determine who will participate. 3. *Appropriate subjects for classes* a. There are many areas of knowledge in health that make excellent subjects for group classes. The subject for the class should be chosen with the following factors in mind: (1) Class members' awareness of health issues in the community (2) Personal needs of class members (3) Health problems that exist in the community. b. Examples of appropriate areas: (1) Reading thermometer (2) Good grooming (3) Weight reduction (4) Food preparation (5) Infant care	1. Each health aide is to teach a group class during the OJT. The successes and failures are to be discussed in the classroom with the trainer.

OBJECTIVES	CONTENT	ACTIVITIES
	4. *Need for professional assistance* a. The health aide supervisor will provide guidance as to what areas require professional assistance in teaching. b. Examples of such areas: weight reduction, care of sick infant, self-examination of breast for cancerous lesions. 5. *Report* a. The health aide assumes the responsibility for preparing a report of his group teaching activity. b. Components of group teaching report: (1) Date (2) Subject (3) Name of persons present (4) Material discussed (5) Reaction of students. 6. *Evaluation* a. The evaluation of the group session has two parts: student and instructor. b. The evaluation can be verbal or written. The written evaluation is preferred, because it results in a permanent record. c. The evaluation should discuss to what extent the teaching met the stated objectives.	

References on Group Teaching

1. Cummins, W. D. and Fagin, Barry, *Principles of Educational Psychology.* New York: The Ronald Press Co. 1958.
2. Anstasi, Ann, *Differential Psychology – Individual and Group Differences in Behavior.* New York: The McMillan Company 1958.
3. Dugold, Arbuckle, *Guiding and Counseling in the Classroom.* Boston: Allyn and Bacon, 1957.
4. Kelly, William A., *Educational Psychology.* Milwaukee: Bruce Publishing Co. 1956.
5. Hicks, Florence Johnson, *The Effectiveness of Two Methods of Teaching Two Groups of Antepartum Patients to Seek Health Supervision for Their Newborn Infants.* Unpublished masters dissertation. Washington, D. C.: The Catholic University of America.

M. WORKING WITH OTHER PERSONS IN THE HELPING ROLE

Overall Objective:

To gain skill in relating to other persons in various helping capacities.

OBJECTIVES	*CONTENT*	*ACTIVITIES*
1. To develop skill in working with other neighborhood workers.	1. *The advantages of working with other neighborhood workers.* a. Allows different viewpoints to be brought to bear on solving a complicated problem. b. Allows special skills of various workers to be utilized in situations where there are mutual goals and/or where the solution of a related problem has a direct effect on the solution of another problem. c. The sharing of information. d. Becoming more familiar with the functions of other workers.	1. During the on-the-job component of the training, the health aides will coordinate their functions with other health and related workers who provide service to the family.
	2. *The relationship to the public health nurse.* a. The public health nurse has the ultimate responsibility for the quality and quantity of care provided the family. b. The public health nurse may refer cases to the health aide. c. The health aide may refer cases to the public health nurse. d. The public health nurse and health aide will share record information and other information regarding the family. e. The health aide and public health nurse may visit family together for purpose of introducing the other and/or working on a mutual problem. f. Any direction given directly to the health aide by a public health nurse must be relayed to the supervisor.	2. Certain problems are to be approached with a team attack. The supervisor will provide the guidance in assisting the health aide in determining those areas that require a concerted effort.
	3. *Relationship to the social worker.* a. The social worker is responsible for handling all social problems encountered by the family. b. The health aide may refer to the social worker.	

c. The social worker may refer a family member to the health aide.

d. If the health aide feels that the family could benefit from a referral to a social agency, this should be discussed with the social worker. The social worker will determine if the referral is necessary and the social worker will make the referral. In no instance should a health aide refer a family to a social agency when there is a social worker working with the family.

4. *Relationship to the teacher and/or school counselor.*

   a. There may be school problems that have a direct relationship to the health of the family, or the converse may be true.

   b. The health aide may approach school personnel to provide information, relate a problem, and/or suggest a joint conference.

   c. The school personnel may refer a school child to the health aide.

   d. The health aide may have to arrange with the school time off for taking the child to a health facility. This should always be done with the knowledge and consent of the parent.

   e. In some instances school personnel may approach the health aide to accompany a group of children to a health facility. For example: dental or eye clinic. This type of activity should be supported and encouraged where possible.

5. *Relationship to community action aide in local community action program.*

   a. Both aides are neighborhood persons who have been given certain skills and perform duties directed toward helping their peers to solve problems.

   b. Aides can share information and work jointly on common goals. Informal conversations are most beneficial in bringing about good working relationships.

   c. Health aide may refer families to the neighborhood worker.

   d. Neighborhood worker may refer families to the health aide.

6. *Relationship to health department, visiting physician and private physician.*

   a. The health aide may refer a family to the health department visiting physician or may instruct the family on how to obtain the services of the visiting physician.

OBJECTIVES	CONTENT	ACTIVITIES
	b. The physician is the person to prescribe drugs and treatments for medical problems. c. The health aide should always obtain the name, address, and telephone number of the family physician. This is quite useful in cases of emergency when a physician is needed. d. Any orders or directions given directly to a health aide by a physician should be relayed to the supervisor. Under no circumstances should the health aide act on the directions of anyone other than the supervisor.	

References on Working with Other Neighborhood Workers

1. Freeman, Ruth, *Public Health Nursing Practice,* Philadelphia. W. B. Saunders Co., 1947.

2. Peplau, Hildegard E., *Interpersonal Relations in Nursing,* New York. G. B. Putnams Sons. 1952 pp. 330.

3. Epstein, Laura, "Differential Use of Staff: A Method to Expand Social Services," *Social Work,* Volume 7, October, 1962.

4. Goldberg, Gertrude, *Untrained Neighborhood Workers in a Social Work Program,* Mobilization for Youth, 1964.

5. Reiff, Robert, "The Use of Non-Professionals in Community Mental Health." Conference on New Careers for Disadvantaged Youth, Howard University, 1964.

6. *The Use of Case Aides in Casework Agencies.* National Social Welfare Assembly. New York, 1959.

7. Weed, Verne, and Denham, William H., "Toward More Use of the Nonprofessional Worker: A Recent Experiment," *Social Work* Vol. 6, pp. 26-36.

SELECTED CONCEPTS AND SUBSTANTIVE ELEMENTS RELATED TO THE NEW CAREERS TRAINING MODEL

The concepts and substantive elements listed below represent those underlying the New Careers Training Model on which core group process and its related curriculum are based. Sources used to derive these concepts mainly are those developed over the past few years by the Institute for Youth Studies, Howard University, and other New Careers Training Programs.

The listing of concepts and substantive elements has as its central aim the belief that there are common ideas about people and their specific and general environments which must be built into and reinforced in any learning situation to achieve New Careers stated outcomes. These common ideas include (1) recognition of the dignity of the individual, (2) his right to self-determination, (3) maximum opportunity for his further development and learning, (4) the experimental basis of learning, and (5) the futility of verbal procedures as a substitute for the personal experiences of the individual.*

As concepts become increasingly refined and understood by both the trainer and the trainee, the supportive substantive elements also become clearer and easier to apply to the learning process. No attempt has been made to arrange the following list in sequential order. The New Careers Program is a system composed of many complementary parts which interact with each other and which cannot be isolated from each other.

1. *Concept:* Success in conducting a New Careers Training Program depends on firm commitments from human service agencies for employment and career mobility for trainees.

Substantive Elements:

A. Training should start only when firm commitments for jobs have been received from the employing agency.
B. Prior to training, the employing agency should have a comprehensive job description for each potential position as a base for core, remediation, skill and OJT curriculum development.
C. Prior to training, the employing agency should have determined realistic career mobility for aides through at least two additional steps with concomitant job descriptions and agency requirements for promotion.
D. Prior to program initiation, there should be a general orientation to the New Careers program for all employing agency staff and trainees.

2. *Concept:* The optimum New Careers Training Model is experience-based from which flows a series of "core" progressions: a core in generic human services; a core in a specific human service, and the specific skill and OJT core.

Substantive Elements:

A. The core of generic human services must stem from the life and job experiences of the trainees.
B. The total training program should support and underline the responsibilities of the trainees to raise issues and problems.
C. All succeeding cores are built on the basic core, detailing specific elements in each human service area and specific occupational area.
D. The experiences of the trainees, prior to and during the training period, are incorporated into the content of the progressions of cores.
E. The New Careers Training Program must move from simple to complex elements.
F. Opportunity is provided for experiencing success, through incremental steps of difficulty.
G. Trainees are better able to learn generalized principles when they are linked to their own concrete experience and/or observation.

3. *Concept:* The New Careers Training Model attempts to "screen and keep people in" rather than out of training.

Substantive Elements:

A. Remediation should be based on the functional needs of the trainee as derived from the job situation.
B. Remediation should prepare the trainee to take and pass appropriate tests or examinations and obtain the necessary credentials leading to further education and/or career mobility.
C. Supportive services (medical, dental, legal, day care, etc.) should be provided trainees to help them maintain continuity of training.
D. Employing agencies must plan for in-service education for aides beyond entry training.
E. On-going formal education and training for career mobility of human service aides should be incorporated into the normal work week, through released time or work-study programs.
F. The New Careers Training Program must accept and build upon the life style of the New Careerist for maximum development of his potential.
G. The trainee must be helped to become aware of the unique role he plays and the contribution he makes to the training program and agency.
H. Professional staff involved in New Careers Training Programs must believe in the value of human service aides and transmit this belief to trainees in the program.
I. Trainees in New Careers must be adequately compensated during the training program.

4. *Concept:* The New Careers Training Model will be most successful when agencies and agency professional personnel restructure their own specific functions and services along with those of New Careerists, involving both the professional and the HSA in the process.

Substantive Elements:

A. Training of skill and OJT professional supervisors should parallel that of the trainees and relate to the

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*A. D. Woodruff. *Basic Concepts of Teaching.* San Francisco, Chandler Publishing Co., 1961.

specific program in which both are involved.

B. Job development and job description in employing agencies should develop based on the optimum utilization of professionals and aides.

C. At the same time training curriculum must be revised and updated to support the on-going process of job development.

D. The possibilities of improving services are greater when the responsibilities of the HSA and the professional complement and supplement one another.

5. *Concept:* The New Careers Training Model emphasizes individual participation in meaningful and challenging activity in all its elements.

Substantive Elements:

A. Trainers – core, skill, OJT, remediation – must see the trainee as able to make decisions and act responsibly consistent with his own interests and needs.

B. The core group provides a medium for the development of human relation skills and their integration with technical skill and OJT experience.

6. *Concept:* The New Careers Training Model provides a new way to help people bridge the gap between lack of credentials in a human service occupation and job entry with potential career mobility.

Substantive Elements:

A. The New Careers process enables the trainee to gain insights into his capacities as well as his deficiencies as he has the opportunity to test skills and perform tasks.

B. The community needs to be familiarized with New Careers concepts and programs – i.e., professional groups, business groups, colleges and universities, community action groups, etc.

C. Linkage with local junior colleges, colleges and universities should be established to provide for continuing education for human service aides.

7. *Concept:* New Careers training programs for human service aides are inseparable from the job situation.

Substantive Elements:

A. Immediate involvement of the trainee in meaningful job-centered experience is critical for overall success.

B. Specialty and OJT experience should provide the basis for curriculum in remediation and the springboard for core group discussion.

C. The optimum training vehicle for New Careers is an informal, small group.

8. *Concept:* Entry training is just that amount of training which can best and most feasibly prepare the trainee to responsibly assume the duties of a HSA in the shortest amount of time.

Substantive Elements:

A. The trainee should be scheduled to function in a service-providing capacity as quickly as possible.

B. The training program must include those necessary skills as early in training as possible to allow the trainee to assume this service function.

C. Prior to training, the job description for the entry job should contain enough detail to reasonably estimate the length of training and responsible involvement of the trainee.

9. *Concept:* The employing agency must be deeply involved in all phases of planning and implementation of the New Careers Training Program.

Substantive Element:

A. Expectations and regulations pertaining to the training program and employing agency must be clearly defined to all participants at the beginning of the New Careers Training Program.